Optometric and Eyeglass Services

Provided by:

Ophthalmologists, Optometrists, Opticians and Eyeglass Providers

Medicaid , CHIP and Other Medical Assistance Programs

MONTANA
Department of Public Health & Human Services

April 2006

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My Medicaid Provider ID Number:
My CHIP Provider ID Number:

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Department of Public Health & Human Services

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Key Contacts

Hours for Key Contacts are 8:00 a.m. to 5:00 p.m. Monday through Friday (Mountain Time), unless otherwise stated. The phone numbers designated "In state" will not work outside Montana.

Provider Enrollment

For enrollment changes or questions:

(800) 624-3958 In and out-of-state
(406) 442-1837 Helena

Send written inquiries to:

Provider Enrollment Unit
P.O. Box 4936
Helena, MT 59604

Provider Relations

For questions about eligibility, payments, denials, general claims questions, or to request provider manuals or fee schedules:

(800) 624-3958 In and out-of-state
(406) 442-1837 Helena

Send written inquiries to:

Provider Relations Unit
P.O. Box 4936
Helena, MT 59604

Claims

Send paper claims to:

Claims Processing Unit
P. O. Box 8000
Helena, MT 59604

Third Party Liability

For questions about private insurance, Medicare or other third-party liability:

(800) 624-3958 In and out-of-state
(406) 442-1837 Helena

Send written inquiries to:

ACS Third Party Liability Unit
P. O. Box 5838
Helena, MT 59604

CHIP Eyeglass Services

CHIP Eyeglass Services
P.O. Box 202951
Helena, MT 59620-2951

(877) 543-7669 Toll free in state
(406) 444-6971 Phone
(406) 444-1899 Fax
chip@state.mt.us E-Mail

CHIP Optometric Services

Blue Cross and Blue Shield of Montana covers optometric services for CHIP clients. For more information or a billing manual, contact:

BlueCHIP
Blue Cross and Blue Shield of Montana
P.O. Box 4309
Helena, MT 59604

(800) 447-7828 Ext. 8647
(406) 447-8647

Optometric Program Officer

Send written inquiries to:

Optometric Program Officer
DPHHS
Medicaid Services Bureau
P.O. Box 202951
Helena, MT 59620

(406) 444-4540 Phone
(406) 444-1861 Fax

Team Care Authorization

For authorization for emergency services provided for clients in the Team Care Program, contact the Surveillance/Utilization Review Section:

(406) 444-4167

All other services must be authorized by the client's designated provider.

Eyeglass Contractor

Walman Optical Company is contracted with DPHHS to provide eyeglasses to Medicaid and CHIP clients. Providers should call Walman to verify the client is eligible for eyeglasses. Dispensing providers may use any of the Montana Walman laboratories:

Keith Valley, Manager
454 Moore Lane, Suite 5
Billings, MT 59101
(406) 252-2143 Phone
(800) 759-5501 Toll free
(800) 642-4920 Fax

Gary Warneke, Manager
1245 South 3 West
Missoula, MT 59801
(406) 549-6429 Phone
(800) 877-3014 Toll free
(800) 551-3335 Fax

Dennis Kuntz, Manager
410 Central Avenue
Great Falls, MT 59401
(406) 761-2872 Phone
(800) 831-5889 Toll free
(406) 761-8194 Fax

Provider's Policy Questions

For policy questions, contact the appropriate division of the Department of Public Health and Human Services; see the *Introduction* chapter in the *General Information For Providers* manual.

Direct Deposit Arrangements

Providers who would like to receive their remittance advices electronically and electronic funds transfer should call the number below.

(406) 444-5283

Client Eligibility

For client eligibility, see the *Client Eligibility and Responsibilities* chapter in the *General Information For Providers* manual.

EDI Technical Help Desk

For questions regarding electronic claims submission:

(800) 987-6719 In and out-of-state
(406) 442-1837 Helena
(406) 442-4402 Fax

Mail to:

ACS
ATTN: MT EDI
P.O. Box 4936
Helena, MT 59604

Secretary of State

The Secretary of State's office publishes the most current version of the Administrative Rules of Montana (ARM):

(406) 444-2055 Phone

Secretary of State
P.O. Box 202801
Helena, MT 59620-2801

Prior Authorization

The following are some of the Department's prior authorization contractors. Providers are expected to refer to their specific provider manual for prior authorization instructions.

Surveillance/Utilization Review

For prior authorization for eye prosthesis, contact SURS at:

(406) 444-0190 Phone
(406) 444-0778 Fax

Send written inquiries to:

Surveillance/Utilization Review
2401 Colonial Drive
P.O. Box 202953
Helena, MT 59620-2953

Prior Authorization (continued)

Provider Relations

Contact Provider Relations to verify that the client is eligible for an eye exam or for PA for dispensing and fitting of contact lenses.

(800) 624-3958 In and out-of-state
(406) 442-1837 Helena

Send written inquiries to:

Provider Relations Unit
P.O. Box 4936
Helena, MT 59604

DPHHS

For prior authorization for transition lenses, tints other than Rose 1 and Rose 2, UV and scratch resistant coating, and polycarbonate lenses for Medicaid and CHIP clients:

For Medicaid clients:

(406) 444-4540 Phone
(406) 444-1861 Fax

Send written inquiries to:

Health Policy and Services Division
Medicaid Bureau - Optometric Program
P.O. Box 202951
Helena, MT 59620-2951

For CHIP clients:

(877) 543-7669 Toll free in state
(406) 444-6971 Phone
(406) 444-1899 Fax
chip@state.mt.us E-Mail

Send written inquiries to:

CHIP Eyeglass Services
P.O. Box 202951
Helena, MT 59620-2951

Key Web Sites

Web Address	Information Available
Virtual Human Services Pavilion (VHSP) vhsp.dphhs.mt.gov	**Select *Human Services* for the following information:** • **Medicaid:** Medicaid Eligibility & Payment System (MEPS). Eligibility and claims history information. • **Senior and Long Term Care:** Provider search, home/housing options, healthy living, government programs, publications, protective/legal services, financial planning. • **DPHHS:** Latest news and events, Mental Health Services Plan information, program information, office locations, divisions, resources, legal information, and links to other state and federal websites. • **Health Policy and Services Division:** Children's Health Insurance Plan (CHIP), and Medicaid provider information such as manuals, newsletters, fee schedules, and enrollment information.
Provider Information Website www.mtmedicaid.org or http://www.dphhs.mt.gov/hpsd/medicaid/medicaid2/index.htm	• Medicaid Information • Medicaid news • Provider manuals • Notices and manual replacement pages • Fee schedules • Remittance advice notices • Forms • Provider enrollment • Frequently asked questions (FAQs) • Upcoming events • Electronic billing information • Newsletters • Key contacts • Links to other websites and more
CHIP Website www.chip.mt.gov	• Information on the Children's Health Insurance Plan (CHIP)
ACS EDI Gateway www.acs-gcro.com/Medicaid_Account/Montana/montana.htm	ACS EDI Gateway is Montana's HIPAA clearinghouse. Visit this website for more information on: • Provider Services • EDI Support • Enrollment • Manuals • Software • Companion Guides
Washington Publishing Company www.wpc-edi.com	• EDI implementation guides • HIPAA implementation guides and other tools • EDI education

MONTANA
Department of Public Health & Human Services

Introduction

Thank you for your willingness to serve clients of the Montana Medicaid program and other medical assistance programs administered by the Department of Public Health and Human Services.

Manual Organization

This manual provides information specifically for optometrists, opticians, and ophthalmologists. Other information for ophthalmologists is included in the *Physician Related Services* manual.

Each chapter has a section titled *Other Programs* that includes information about other Department programs such as the Mental Health Services Plan (MHSP) and the Children's Health Insurance Plan (CHIP). Other essential information for providers is contained in the separate *General Information For Providers* manual. Each provider is asked to review both the general manual and the specific manual for his or her provider type.

A table of contents and an index allow you to quickly find answers to most questions. The margins contain important notes with extra space for writing notes. There is a list of *Key Contacts* at the beginning of each manual. We have also included a space on the back side of the front cover to record your Medicaid and CHIP provider ID numbers for quick reference when calling Provider Relations.

Manual Maintenance

Manuals must be kept current. Changes to manuals are provided through notices and replacement pages which are available on the *Provider Information* website (see *Key Contacts*). When replacing a page in a manual, file the old pages in the back of the manual for use with claims that originated under the old policy.

Providers are responsible for knowing and following current laws and regulations.

Rule References

Providers must be familiar with all current rules and regulations governing the Montana Medicaid program. Provider manuals are to assist providers in billing Medicaid; they do not contain all Medicaid rules and regulations. Rule citations in the text are a reference tool; they are not a summary of the entire rule. In the event that a manual conflicts with a rule, the rule prevails. Links to rules are available on the Provider Information website (see *Key Contacts*). Paper copies of rules are available through Provider Relations and the Secretary of State's office (see *Key Contacts*). In addition to the general Medicaid rules outlined in the *General Information For Providers* manual, the following rules and regulations are also applicable to the optometric and eyeglass programs:

- Code of Federal Regulations (CFR)
  - 42 CFR 440.60 Medicaid or Other Remedial Care Provided by Licensed Practitioners
  - 42 CFR 440.120 Prescribed Drugs, Dentures, Prosthetic Devices and Eyeglasses
- Montana Codes Annotated (MCA)
  - MCA 37-10-101 - 37-10-313 Optometry
- Administrative Rules of Montana (ARM)
  - ARM 37.86.2001 - 37.86.2005 Optometric
  - ARM 37.86.2101 - 37.86.2105 Eyeglasses

Claims Review (MCA 53-6-111, ARM 37.85.406)

The Department is committed to paying Medicaid provider's claims as quickly as possible. Medicaid claims are electronically processed and usually are not reviewed by medical experts prior to payment to determine if the services provided were appropriately billed. Although the computerized system can detect and deny some erroneous claims, there are many erroneous claims which it cannot detect. For this reason, payment of a claim does not mean that the service was correctly billed or the payment made to the provider was correct. Periodic retrospective reviews are performed which may lead to the discovery of incorrect billing or incorrect payment. If a claim is paid and the Department later discovers that the service was incorrectly billed or paid or the claim was erroneous in some other way, the Department is required by federal regulation to recover any overpayment, regardless of whether the incorrect payment was the result of Department or provider error or other cause.

Getting Questions Answered

The provider manuals are designed to answer most questions; however, questions may arise that require a call to a specific group (such as Provider Relations or a prior authorization unit). The list of *Key Contacts* at the front of this manual has important phone numbers and addresses pertaining to this manual. The *Introduction* chapter in the *General Information For Providers* manual also has a list of contacts for specific program policy information. Providers should also read the monthly *Montana Medicaid Claim Jumper* newsletter for Medicaid updates and changes. Medicaid manuals, notices, replacement pages, fee schedules, forms, and much more are available on the *Provider Information* website (see *Key Contacts*).

Covered Services

General Coverage Principles

This chapter provides covered services information that applies specifically to optometrists, opticians, and ophthalmologists. It also covers information for the prescription of corrective lenses. Like all health care services received by Medicaid clients, services provided by these practitioners must also meet the general requirements listed in the *Provider Requirements* chapter of the *General Information For Providers* manual. Ophthalmologists should also be familiar with the *Physician Related Services* manual.

Services within scope of practice (ARM 37.85.401, 37.86.2001)

Services are covered when they are within the scope of the provider's practice.

Dispensing services (ARM 37.86.2102)

Dispensing services may be provided by ophthalmologists, optometrists, and opticians. Employees may also dispense as long as the provider complies with laws, rules, and licensing requirements regarding supervision and assistants or aides.

Services for clients with limited Medicaid coverage

Medicaid generally does not cover eye exams or eyeglasses for clients with *Basic Medicaid* or *QMB only* coverage. Always check client eligibility before providing services (see the *General Information For Providers* manual, *Client Eligibility* chapter, and *Eye exams* and *Eyeglass services* in this chapter for limits). However, Medicaid may cover eye exams for these clients under the following conditions.

- ***Following cataract surgery.*** Clients who have *QMB only* coverage are only eligible for eyeglasses following cataract surgery when Medicare approves the eyeglasses claim. Medicaid considers the Medicare coinsurance and deductible for this claim. Eyeglasses for these clients are not provided through the Department's eyeglass contractor but through Medicare's purchasing plan. See the *Coordination of Benefits* chapter in this manual for more information.
- ***Essential for employment.*** When the local office of public assistance determines a service is *essential for employment*, Medicaid may cover eye exams and eyeglasses. The client must present an *Essential for Employment* form at the exam. Eyeglasses must be chosen from the contractor (see *Key Contacts*), and the *Essential for Employment* form must be sent with the prescription to the eyeglass contractor when ordering (see *Eyeglass Ordering Procedure* later in this chapter).

- ***Diabetic diagnosis.*** Medicaid covers eye exams for clients with basic Medicaid coverage who have a diabetic diagnosis (see following table). Eyeglasses are not covered for these clients.
- ***Certain eye conditions.*** Medicaid covers eye exams for clients with Basic Medicaid coverage who have certain eye conditions (see following table). Eyeglasses are not covered for these clients.

Diagnosis Codes for Which Basic Medicaid Covers Eye Exams

360.0 - 366.9	374.5 - 377.9	379.29	870.0 - 871.9
368.1 - 368.2	379.00 - 379.19	379.31 - 379.39	918.1 - 918.9
368.40 - 368.47	379.23	379.54	930.0 - 930.1
370.0 - 372.39	379.26	379.8 - 379.99	076.0 - 077.99
372.6 - 374.23	V58.69	250.00 - 250.93	

Services for children

The Early and Periodic Screening, Diagnosis and Treatment Program (EPSDT) is a comprehensive approach to health care for Medicaid clients ages 20 and under. It is designed to prevent, identify, and then treat health problems before they become disabling. Under EPSDT, Medicaid eligible children may receive any medically necessary covered service, including all eye exam and eyeglass services described in this manual. All applicable PASSPORT To Health and prior authorization requirements apply.

Non-covered services (ARM 37.85.206, 37.85.207, 37.85.406)

Some services not covered by Medicaid include the following:

- Services considered experimental or investigational
- Dispensing fees for a client who is not eligible for lenses and/or frames within the 730 day time period
- Services that the provider did not personally provide. The main exception is that the dispensing service may be performed by the provider's employee when it is allowed by law.

Use the current fee schedule for your provider type to verify coverage for specific services.

Importance of fee schedules

The easiest way to verify coverage for a specific service is to check the Department's fee schedule. Fee schedules list Medicaid covered codes and provide clarification of indicators such as whether a code requires prior authorization, can be applied to a co-surgery, can be billed bilaterally, etc. All services provided must also meet the coverage criteria listed in the *Provider Requirements* chapter of the *General Information For Providers* manual and in this chapter. Use the current fee schedule in conjunction with the more detailed coding

descriptions listed in the current CPT-4 and HCPCS Level II coding books. Take care to use the fee schedule and coding books that pertain to the date of service.

Current fee schedules are available on the *Provider Information* website (see *Key Contacts*). For disk or hard copy, contact Provider Relations (see *Key Contacts*).

Retroactive Eligibility

Medicaid does not cover eyeglasses for clients who become retroactively eligible for Medicaid when the eyeglasses were purchased before retroactive eligibility was determined. However, Medicaid does cover eye exams for retroactively eligible clients. For example, suppose that a client had an eye exam and purchased eyeglasses on July 15. On September 1, the Department determined the client was eligible for Medicaid retroactive to July 1. Medicaid would pay for the eye exam but not for the eyeglasses.

Coverage of Specific Services

The following are coverage rules for specific services provided by optometrists, opticians, and ophthalmologists. Due to limits on exams and eyeglasses, before providing these services, the provider should contact Provider Relations (see *Key Contacts*) to verify the client is currently eligible for an exam, and contact the eyeglass contractor (see *Key Contacts*) to verify the client is eligible for eyeglasses. Medicaid will only pay for eyeglasses and frames purchased through the Department's eyeglass contractor (see *Key Contacts*). All services are subject to post payment review and payment recovery if they are not medically necessary (see the *Surveillance/Utilization Review* chapter in the *General Information For Providers* manual).

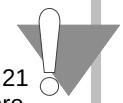
Medicaid will only pay for eyeglasses and frames purchased through the Department's eyeglass contractor

Contact lenses

Contact lenses are covered only when medically necessary and not for cosmetic reasons. Dispensing providers must obtain prior authorization for all contact lenses and dispensing fees (see the *Prior Authorization* chapter in this manual). The same limits that apply to eyeglasses and repairs also apply to contacts. Contact lenses are not provided by the eyeglass contractor and therefore may be provided by other providers. Medicaid covers them when the client has one the following conditions:

- Keratoconus
- Sight that cannot be corrected to 20/40 with eyeglasses
- Aphakia
- Anisometropia of 2 diopters or more

If a provider does not check client eligibility prior to an exam, and the claim is denied because the client's exam limit was exceeded, the provider cannot bill Medicaid or the client.



Adults (age 21 and older) are limited to one eye exam and one pair of eyeglasses every 730 days. Children (ages 20 and under) are limited to one eye exam and one pair of eyeglasses every 365 days.

Eye exams

Before providing an eye exam, verify that the client is eligible for an exam by contacting Provider Relations (see *Key Contacts*). Medicaid clients ages 21 and over are limited to one eye examination for determining refractive state every 730 days. Medicaid clients ages 20 and under are limited to one eye examination for determining refractive state every 365 days. The Department allows exceptions to these limits when one of the following conditions exists:

- Following cataract surgery, when more than one exam during the respective period is necessary
- A screening shows a loss of one line acuity with present eyeglasses
- Adult diabetic clients may have exams every 365 days

Eyeglass services

Before providing eyeglasses to a client, verify that the client is eligible by contacting the eyeglass contractor (see *Key Contacts*). Adults ages 21 and older are eligible for eyeglasses every 730 days. If the client has a diagnosed medical condition that prohibits the use of bifocals, Medicaid may cover two pairs of single vision eyeglasses every 730 days. Although prior authorization is not required, the provider must document the client's inability to use bifocals. Children ages 20 and under are eligible for eyeglasses every 365 days. If one of the following circumstances exists within the respective time limits, lenses only will be replaced:

- .50 diopter change in correction in sphere
- .75 diopter change in cylinder
- .5 prism diopter change in vertical prism
- .50 diopter change in the near reading power
- A minimum of a 5 degree change in axis of any cylinder less than or equal to 3.00 diopters
- A minimum of a 3 degree change in axis of any cylinder greater than 3.00 diopters
- Any 1 prism diopter or more change in lateral prism

If any one of these changes is in one eye, Medicaid will cover that lens only. Medicaid will not cover a new frame at the time of a prescription change within the respective time limits.

Eyeglasses are covered for an initial/new prescription when the client has at least one of the following circumstances in one or both eyes:

- Cataract surgery
- .50 diopter correction in sphere
- .75 diopter correction in cylinder
- .5 prism diopter correction in vertical prism

- .50 diopter correction in near reading power
- Any 1 prism diopter or more correction in lateral prism

Frame services

The eyeglass contractor will provide a list of Medicaid-covered frames to dispensing providers.

Medicaid clients have the option of using their "existing frames" and Medicaid will cover lenses. The existing frame is a frame that the client owns or purchases. When a client chooses to use an existing frame, the following apply:

- Dispensing providers will evaluate existing frames to ensure lenses can be inserted.
- The eyeglass contractor will decide if the existing frame can be used for Medicaid covered lenses. If the existing frame cannot be used, the eyeglass contractor will inform the dispensing provider.
- If the existing frame breaks (after lenses are dispensed to the client), Medicaid will pay for a contract frame but not new lenses. The client can choose to pay privately for new lenses or find a contract frame that the lenses will fit. New lenses are not covered in this case.

Lens add-ons

Medicaid covers some "add-on" or special features for eyeglass lenses, and some are available on a private pay basis (see following table).

Lens Add-Ons

Lens Feature	Medicaid Covers for Children (Ages 20 & Under)	Medicaid Covers for Adults (Ages 21 and Older)	Medicaid Contract Rate Per Lens
Photochromic - plastic (i.e. Transition)	Yes - if medically necessary	No	$18.50
Photochromic - Glass (i.e. photogray, photobrown)	Yes - if medically necessary	No	$4.50
Progressive	No, but Medicaid will pay $21.00 and client must pay balance	No, but Medicaid will pay $21.00 and client must pay balance	VIP $30.50 XL $30.50 Percepta $34.00 Comfort $35.50
Polycarbonate lenses (Single vision, Bifocal, or Trifocal lenses)	Yes - if client is monocular	Yes - if client is monocular	$4.00
Tints Rose 1 and Rose 2 (applicable to CR-39 and Polycarbonate lenses only)	Yes	Yes	No charge

Lens Add-Ons (continued)

Lens Feature	Medicaid Covers for Children (Ages 20 & Under)	Medicaid Covers for Adults (Ages 21 and Older)	Medicaid Contract Rate Per Lens
Tints other than Rose 1 and Rose 2 (applicable to CR-39 and Polycarbonate lenses only)	Yes - if medically necessary	No	$1.25
UV and scratch-resistant coatings	Yes - if medically necessary	No	$1.50
Slab-off and fresnell prism	Yes - if medically necessary	Yes - if medically necessary	No charge

Any lens style, lens material, tint, coating lens enhancement (polished edge, etc.) not specifically noted above or within this manual will be billed to the dispensing provider at the eyeglass contractor's normal and customary charges. The Department requests that providers bill clients the Walman Medicaid rate for scratch guard and polycarbonate lenses. For other add-ons noted above that are not covered by Medicaid, payment is a private arrangement between the client and the provider. This means that the provider may charge either the usual private pay rate or the Walman Medicaid rate to the client.

Lens styles and materials

All eyeglass lenses fabricated by the eyeglass contractor for Medicaid clients must be in the edged form, edged to shape and size for a specific frame and returned to the dispensing provider as "lenses only," or edged and mounted into a specific frame and returned to the dispensing provider as "complete Rx order." Orders for "uncut" lenses are not accepted.

Medicaid covers the following lens styles:

- Single vision
- Flattop segments 25, 28, 35
- Round 22
- Flattop trifocals 7 x 25, 7 x 28
- Executive style bifocals.

Medicaid covers the following lens materials (no high index):

- Glass
- CR-39
- Polycarbonate for monocular clients only. Medicaid clients who are not monocular can choose polycarbonate lenses and pay the difference as an add-on (see previous table of *Lens Add-Ons*).

Replacement lenses and frames

All frames provided by the Medicaid contractor carry a 24-month manufacturer warranty on replacement fronts and temples. Medicaid clients must bring their broken frames into the dispensing provider for the contractor to repair. No new frame style or color can replace the broken frame.

If an adult (ages 21 and older) loses his or her eyeglasses within the 24 months, Medicaid will not cover another pair. If an adult's lenses are broken or unusable, the client is eligible for replacement lenses (not frames) 12 months after the initial dispensing of contract eyeglasses.

Eyeglass Breakage and Loss Form

A. TO BE COMPLETED BY THE PATIENT

Please check one of the following reasons why you are requesting replacement of your eyeglasses.

☐ Eyeglasses have been lost or stolen (children only).
☒ Frame is broken.
☐ One lens is unusable due to scratches or breakage.
☒ Both lenses are unusable due to scratches or breakage.
☐ Other. Please explain_____

12/10/02 Julie Smith
Date Patient Signature (parent for a minor)

##########

B. TO BE COMPLETED BY PROVIDER

☒ Patient brought in broken: (frame) lens / (lenses.)
(Circle Applicable)

12/10/02 Alex Optometrist
Date Provider Signature

If a child (ages 20 and under) loses or breaks the first pair of eyeglasses, and the damage is not covered by the warranty, Medicaid will replace one pair of eyeglasses within the 365 day period. Additional replacement requests must be reviewed by the Department Program Officer (see *Key Contacts*). Parents/guardians may purchase additional replacement eyeglasses at the Medicaid contract rate.

For lens and/or frame replacements, complete an *Eyeglass Breakage and Loss* form (see sample). Please circle *lens* if one lens is broken, and *lenses* if both lenses are broken. This form may be copied from *Appendix A Forms* or downloaded from the website.

Eyeglass Ordering Procedures

Providers must complete the Montana Medicaid Rx Form to order eyeglasses from the Department's contractor (see *Appendix A Forms*).

Tips for completing the Montana Medicaid Rx Form

- The date of service for dispensing eyeglasses (measuring, verifying, and fitting) is the date the eyeglasses are ordered from the contractor.
- The date of service for eyeglass materials is the date the order is received by the eyeglass contractor.
- Encounters with the client on and after the date the glasses are dispensed are considered follow-up and are covered within the measuring, verifying, and fitting fee.

When the date of service is near the end of the month, please fax orders to the eyeglasses contractor before 3:00 p.m. to ensure the client's eligibility, which can change monthly.

- Orders received by the eyeglass contractor after 3:00 p.m. will appear on the next business day and billed with this date of service.
- When the date of service is near the end of the month, please fax orders to the contractor. This will help ensure the client is eligible for eyeglasses since eligibility can change monthly. If you experience any difficulty faxing the contractor, please contact the contractor manager immediately (see *Key Contacts*).
- When completing the *Frame Information* section, remember the following:
  - Select *Supply* when ordering contract frame and lenses
  - Select *Lenses Only* when ordering lenses only
  - Check the *EPSDT* box when the Medicaid client is age 20 and under
  - *2nd PR S.V.* is used when ordering two pairs of single vision eyeglasses (one for distance and one for reading) when a Medicaid client cannot wear multi-focal eyeglasses. An ophthalmologist or optometrist must keep documentation of the client's inability to wear multi-focal eyeglasses.
  - *Rx Change* is used when a lens is ordered due to a prescription change which meets Medicaid guidelines (see *Eyeglass services* earlier in this chapter).

Submitting the Medicaid Rx form

- Attach a copy of the Faxback or MEPS printout verifying eligibility for the client (see the *Verifying Client Eligibility* section in the *General Information For Providers* manual) to the order form.
- If the service is "essential for employment," include a copy of the form with the order.
- Mail or fax the order form to the eyeglass contractor (see *Key Contacts*). Phone orders are not accepted. To ensure orders will be processed accurately and on time, all sections of the order form must be completed.
- Errors in the fabrication of eyeglasses made by the eyeglass contractor will be corrected by the contractor at no additional charge.
- If the dispensing provider makes a mistake on a prescription, the eyeglass contractor will correct the error (create a new lens with the correct prescription) and bill the dispensing provider at Medicaid contract rates.

Other Programs

This is how the information in this chapter applies to Department programs other than Medicaid.

Children's Health Insurance Plan (CHIP)

Eyeglass services are covered by CHIP, but optometric services are covered by the BlueCHIP Plan of Blue Cross and Blue Shield of Montana (see *Key Contacts*). Most of the eyeglass services information in this chapter applies to CHIP clients. The exceptions are as follows:

- Where the above text says "Medicaid covers," either CHIP or BlueCHIP covers for CHIP clients.
- CHIP clients do not receive retroactive eligibility.
- CHIP clients are 18 years of age and under.
- CHIP clients are eligible for eyeglasses every 365 days.
- CHIP clients are not eligible for replacement lenses or frames that are not covered under warranty.

Additional information regarding CHIP is available on the *Provider Information* website (see *Key Contacts*).

Mental Health Services Plan (MHSP)

Eye exams and eyeglasses are not covered under the Mental Health Services Plan (MHSP). See the *Mental Health Services Plan* manual available on the *Provider Information* website.

MONTANA
Department of Public Health & Human Services

Prior Authorization

What Are PASSPORT, Prior Authorization and the Team Care Programs? (ARM 37.86.5101 - 5120)

PASSPORT To Health, prior authorization (PA), and the Team Care Program are three examples of the Department's efforts to ensure the appropriate use of Medicaid services. In each program, providers need approval before services are provided to a particular client. PASSPORT requirements do not apply to optometric, ophthalmologist and eyeglass services, but prior authorization is required for some services, and the client may be part of the Team Care Program.

PASSPORT requirements do not apply to optometric, ophthalmologist, and eyeglass services.

- ***PASSPORT To Health Managed Care Program*** is Montana Medicaid's Primary Care Case Management (PCCM) Program and has been very successful since implementation in 1993. Under PASSPORT, Medicaid clients choose one primary care provider and develop an ongoing relationship that provides a "medical home." With some exceptions, all services to PASSPORT clients must be provided or approved by the PASSPORT provider. The PASSPORT mission is to manage the delivery of health care to Montana Medicaid clients in order to improve or maintain access and quality while minimizing use of health care resources. Approximately 68% of the Medicaid population is enrolled in PASSPORT. All Montana Medicaid clients must participate in PASSPORT except for nursing home and institution residents, clients with Medicare coverage, medically needy clients with incurments, or clients living in non-PASSPORT counties. Any Montana Medicaid provider may be a PASSPORT provider if primary care is within his or her scope of practice. PASSPORT saves the Medicaid program approximately $20 million each year. These savings allow improved benefits elsewhere in the Medicaid program.
- ***Prior authorization*** refers to a short list of services. If a service requires prior authorization, the requirement exists for all Medicaid clients. See *Prior Authorization* later in this chapter.
- ***Team Care*** is a utilization control and management program designed to educate clients on how to effectively use the Medicaid system. Clients with a history of using services at an amount or frequency that is not medically necessary are enrolled in Team Care. These clients must enroll in PASSPORT, select a PASSPORT primary care provider (PCP) and a single pharmacy, and call the Nurse First Advice Line prior to accessing Medicaid health services (except for emergency services). These clients receive extensive outreach and education from Nurse First nurses and are instructed on the proper use of the Montana Medicaid healthcare system. Team care is a component of the PASSPORT program, and all PASSPORT rules and guidelines apply to these clients. For more information on the Team Care Program and Nurse First, see the *General Information For Providers* manual or the *Team Care* page on the Provider Information website (see *Key Contacts*).

Prior Authorization

Some services require prior authorization (PA) before providing them. When seeking PA, keep in mind the following:

- The referring provider should initiate all authorization requests.
- Always refer to the current Medicaid fee schedule for PA requirements on specific services.
- Have all required documentation included in the packet before submitting for PA. See the following *PA Criteria for Specific Services* table for documentation requirements.

PA Criteria for Specific Services

Service	PA Contact	Documentation Requirements

• **Dispensing and fitting of contact lenses**	Provider Relations
	P.O. Box 4936
	Helena, MT 59604
	
	Phone:
	(406) 442-1837 Helena
	(800) 624-3958 In and out-of-state
		• PA required for contact lenses and dispensing fees.
		• Diagnosis must be one of the following:
		  • Keratoconus
		  • Aphakia
		  • Sight cannot be corrected to 20/40 with eyeglasses
		  • Anisometropia of 2 diopters or more

• **Transition lenses** • **Tints other than Rose 1 and Rose 2 (including photochromic tints)** • **UV and scratch resistant coating** • **Polycarbonate lenses**	Health Policy and Services Division Medicaid Bureau - Optometric Program P.O. Box 202951 Helena, MT 59620-2951 **Fax:** (406) 444-1861	• Requests for authorization must be submitted in writing or by fax. • Include diagnosis and sufficient documentation from the optometrist or ophthalmologist that transition lenses, tints, or UV and scratch resistant coating are medically necessary. • For polycarbonate lenses, include documentation verifying client is monocular.
• **Eye prosthesis**	Surveillance/Utilization Review Section P.O. Box 202953 Helena, MT 59620-2953 **Phone:** (406) 444-0190 Helena and out of state (406) 444-1441 Helena and out of state **Fax:** (406) 444-0778	• Documentation that supports medical necessity • Documentation regarding the client's ability to comply with any required after care • Letters of justification from referring physician • Documentation should be provided at least two weeks prior to the procedure date.

Other Programs

Clients enrolled in the Children's Health Insurance Plan (CHIP) are not enrolled in PASSPORT, so the PASSPORT requirements in this chapter do not apply. The prior authorization requirements apply to CHIP eyeglass services. See *Key Contacts* for prior authorization contacts and the *Prior Authorization* chapter for more information. Optometric services are covered the BlueCHIP plan of Blue Cross and Blue Shield of Montana.

Eye exams and eyeglasses are not covered under the Mental Health Services Plan (MHSP). Refer to the *Mental Health Services Plan* manual on the *Provider Information* website.

MONTANA
Department of Public Health & Human Services

Coordination of Benefits

When Clients Have Other Coverage

Medicaid clients often have coverage through Medicare, workers' compensation, employment-based coverage, individually purchased coverage, etc. Coordination of benefits is the process of determining which source of coverage is the primary payer in a particular situation. In general, providers must bill other carriers before billing Medicaid, but there are some exceptions (see *Exceptions to Billing Third Party First* later in this chapter). Medicare coverage is processed differently than other sources of coverage.

Identifying Other Sources of Coverage

The client's Medicaid ID card may list other payers such as Medicare or other third party payers (see *Client Eligibility and Responsibilities* in the *General Information For Providers* manual). If a client has Medicare, the Medicare ID number is listed on the card. If a client has other coverage (excluding Medicare), it will be shown under the "TPL" section of the ID card. Some examples of third party payers include:

- Private health insurance
- Employment-related health insurance
- Workers' compensation insurance*
- Health insurance from an absent parent
- Automobile insurance*
- Court judgments and settlements*
- Long term care insurance

*These third party payers (and others) may **not** be listed on the client's ID card.

Medicare claims are processed differently than other sources of coverage.

Providers must use the same procedures for locating third party sources for Medicaid clients as for their non-Medicaid clients. Providers cannot refuse service because of a third party payer or potential third party payer.

When a Client Has Medicare

Medicare claims are processed and paid differently than claims involving other payers. The other sources of coverage are referred to as "third party liability" (TPL), but Medicare is not.

Medicare Part A claims

Medicare Part A covers inpatient hospital care, skilled nursing care and other services. Medicare Part A services are covered in more detail in specific program manuals where the providers bill for Part A services.

Medicare Part B crossover claims

To avoid confusion and paperwork, submit Medicare Part B crossover claims to Medicaid only when necessary.

Medicare Part B covers physician care, eye exams, and other services. The Department has an agreement with Medicare Part B carriers for Montana (BlueCross BlueShield of Montana and the Durable Medical Equipment Regional Carrier [DMERC]). Under this agreement, the carriers provide the Department with a magnetic tape of CMS-1500 (formerly HCFA-1500) claims for clients who have both Medicare and Medicaid coverage. In order to have claims automatically cross over from Medicare to Medicaid, the provider must:

- Accept Medicare assignment (otherwise payment and the Explanation of Medicare Benefits (EOMB) go directly to the client and will not cross over).
- Submit their Medicare and Medicaid provider numbers to Provider Relations (see *Key Contacts*).

When submitting electronic claims with paper attachments, see the *Billing Electronically with Paper Attachments* section of the *Billing Procedures* chapter in this manual.

In these situations, providers need not submit Medicare Part B crossover claims to Medicaid. Medicare will process the claim, submit it to Medicaid, and send the provider an EOMB. Providers must check the EOMB for the statement indicating that the claim has been referred to Medicaid for further processing. It is the provider's responsibility to follow up on crossover claims and make sure they are correctly billed to Medicaid within the timely filing limit (see *Billing Procedures*).

When Medicare pays or denies a service

- When Medicare pays an eye exam claim for a provider that is set up for automatic crossover, the claim should automatically cross over to Medicaid for processing, so the provider does not need to submit these claims to Medicaid.

  Providers that are not set up for automatic crossover should submit a claim to Medicaid after Medicare pays, and Medicaid will consider the claim for payment (see *Submitting Medicare claims to Medicaid* later in this chapter).

  If Medicare denies an eye exam claim, submit the claim to Medicaid (see *Submitting Medicare claims to Medicaid* later in this chapter).

All Part B Crossover claims submitted to Medicaid before Medicare's 45-day response time will be returned to the provider.

- Clients who have Medicare/QMB or Medicare/Medicaid coverage must choose whether to access their Medicare or Medicaid benefits for eyeglasses. If a client chooses to use Medicare, do not bill Medicaid, and any claims that cross over from Medicare will be denied.

- For clients who have QMB only coverage, the provider bills Medicare first for eyeglass claims, and if Medicare pays the claim, Medicaid will consider the claim for payment. If Medicare denies the claim, Medicaid will also deny the claim. For more information on QMB, see the *General Information For Providers* manual, *Client Eligibility* chapter.

When Medicaid does not respond to crossover claims

When Medicaid does not respond within 45 days of the provider receiving the Medicare EOMB, submit a claim, with a copy of the Medicare EOMB, to Medicaid for processing.

Remember to submit Medicare crossover claims to Medicaid only:

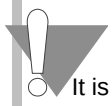
- When the "referral to Medicaid" statement is missing from the provider's EOMB.
- When the provider does not hear from Medicaid within 45 days of receiving the Medicare EOMB.

Submitting Medicare claims to Medicaid

When submitting a paper claim to Medicaid, attach the Medicare EOMB and use Medicaid billing instructions and codes. Medicare's instructions, codes, and modifiers may not be the same as Medicaid's. The claim must also include the Medicaid provider number and Medicaid client ID number.

When a Client Has TPL (ARM 37.85.407)

When a Medicaid client has additional medical coverage (other than Medicare), it is often referred to as third party liability or TPL. In most cases, providers must bill other insurance carriers before billing Medicaid.



It is the provider's responsibility to follow up on TPL claims and make sure they are billed correctly to Medicaid within the 12-month timely filing period.

Providers are required to notify their clients that any funds the client receives from third party payers (when the services were billed to Medicaid) must be turned over to the Department. The following words printed on the client's statement will fulfill this requirement: "When services are covered by Medicaid and another source, any payment the client receives from the other source must be turned over to Medicaid."

Exceptions to billing third party first

In a few cases, providers may bill Medicaid first.

- When a Medicaid client is also covered by Indian Health Service (IHS) or the Montana Crime Victim's Compensation Fund, providers must bill Medicaid before IHS or Crime Victim's. These are not considered third party liability.
- If the third party has only potential liability, such as automobile insurance, the provider may bill Medicaid first. Do not indicate the potential third party on the claim. Instead, notify the Department of the potential third party by sending the claim and a note to the ACS Third Party Liability Unit (see *Key Contacts*).

Requesting an exemption

Providers may request to bill Medicaid first under certain circumstances. In each of these cases, the claim and required information must be sent directly to the ACS Third Party Liability Unit (see *Key Contacts*).

- When a provider is unable to obtain a valid *assignment of benefits* (see *Definitions*), the provider must submit the claim with documentation that the provider attempted to obtain assignment and certification that the attempt was unsuccessful.
- When the child support enforcement division has required an absent parent to have insurance on a child, the claim can be submitted to Medicaid when the following requirements are met:
    1. The third party carrier has been billed, and 30 days or more have passed since the date of service.
    2. The claim is accompanied by a certification that the claim was billed to the third party carrier, and payment or denial has not been received.
- If another insurance has been billed, and 90 days have passed with no response, attach a note to the claim explaining that the insurance company has been billed (or attach a copy of the letter sent to the insurance company). Include the date the claim was submitted to the insurance company and certification that there has been no response.
- When the provider has billed the third party insurance and has received a non-specific denial (e.g., no client name, date of service, amount billed), submit the claim with a copy of the denial and a letter of explanation directly to the TPL Unit (see *Key Contacts*) in order to avoid missing the timely filing deadline.

When the third party pays or denies a service

When a third party payer is involved (excluding Medicare) and the other payer:

- Pays the claim, indicate the amount paid in the “amount paid” field of the claim when submitting to Medicaid for processing. These claims may be submitted either electronically or on paper.
- Allows the claim, and the allowed amount went toward client’s deductible, include the insurance Explanation of Benefits (EOB) when billing Medicaid. These claims must be submitted on paper.
- Denies the claim, include a copy of the denial (including the reason and the reason explanation) with the claim, and submit to Medicaid.
- Denies a line on the claim, bill the denied lines together on a separate claim and submit to Medicaid. Include the explanation of benefits (EOB) from the other payer as well as an explanation of the reason for denial (e.g., definition of denial codes).

When the third party does not respond

If another insurance has been billed, and 90 days have passed with no response, bill Medicaid as follows:

- Attach to the claim a note explaining that the insurance company has been billed (or attach a copy of the letter sent to the insurance company).
- Include the date the claim was submitted to the insurance company.
- Send this information to the ACS Third Party Liability Unit (see *Key Contacts*).

If the provider receives a payment from a third party after the Department has paid the provider, the provider must return the lower of the two payments to the Department within 60 days.

Other Programs

The information in this chapter does not apply to the Children's Health Insurance Plan (CHIP) or the Mental Health Services Plan (MHSP). The MHSP manual is available on the *Provider Information* website (see *Key Contacts*).

Billing Procedures

Claim Forms

Services provided by optometrists, opticians, and ophthalmologists must be billed either electronically on a Professional claim or on a CMS-1500 paper claim form (formerly known as the HCFA-1500). CMS-1500 forms are available from various publishing companies; they are not available from the Department or Provider Relations.

Timely Filing Limits (ARM 37.85.406)

Providers must submit clean claims to Medicaid within the latest of:

- Twelve months from whichever is later:
  - the date of service
  - the date retroactive eligibility or disability is determined
- ***Medicare Crossover Claims:*** Six months from the date on the Medicare explanation of benefits approving the service (if the Medicare claim was timely filed and the client was eligible for Medicare at the time the Medicare claim was filed).
- ***Claims involving other third party payers (excluding Medicare):*** Six months from the date on an adjustment notice from a third party payer who has previously processed the claim for the same service, and the adjustment notice is dated after the periods described above.

Clean claims are claims that can be processed without additional information or action from the provider. The submission date is defined as the date that the claim was received by the Department or the claims processing contractor. All problems with claims must be resolved within this 12 month period.

Tips to avoid timely filing denials

- Correct and resubmit denied claims promptly (see the *Remittance Advices and Adjustments* chapter in this manual).
- If a claim submitted to Medicaid does not appear on the remittance advice within 30 days, contact Provider Relations for claim status (see *Key Contacts*).
- If another insurer has been billed and 90 days have passed with no response, you can bill Medicaid (see the *Coordination of Benefits* chapter in this manual for more information).
- To meet timely filing requirements for Medicare/Medicaid crossover claims, see the *Coordination of Benefits* chapter in this manual.

When To Bill Medicaid Clients (ARM 37.85.406)

In most circumstances, providers may not bill Medicaid clients for services covered under Medicaid. The main exception is that providers may collect cost sharing from clients.

If a provider bills Medicaid and the claim is denied because the client is not eligible, the provider may bill the client directly.

More specifically, providers cannot bill clients directly:

- For the difference between charges and the amount Medicaid paid.
- For a covered service provided to a Medicaid-enrolled client who was accepted as a Medicaid client by the provider, even if the claim was denied.
- When a third-party payer does not respond.
- When a client fails to arrive for a scheduled appointment. Medicaid may not be billed for no-show appointments either.
- When services are free to the client, such as in a public health clinic. Medicaid may not be billed for those services either.

Under certain circumstances, providers may need a signed agreement in order to bill a Medicaid client (see the following table).

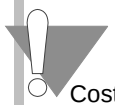
When to Bill a Medicaid Client (ARM 37.85.406)

	• **Client Is Medicaid Enrolled** • **Provider Accepts Client as a Medicaid Client**	• **Client Is Medicaid Enrolled** • **Provider Does Not Accept Client as a Medicaid Client**	• **Client Is Not Medicaid Enrolled**
Service is covered by Medicaid	Provider can bill client **only** for cost sharing	Provider can bill Medicaid client if the client has signed a routine agreement	Provider can bill client
Service is not covered by Medicaid	Provider can bill client only if custom agreement has been made between client and provider before providing the service	Provider can bill Medicaid client if the client has signed a routine agreement	Provider can bill client

Routine Agreement: This may be a routine agreement between the provider and client which states that the client is not accepted as a Medicaid client, and that he or she must pay for the services received.

Custom Agreement: This agreement lists the service the client is receiving and states that the service is not covered by Medicaid and that the client will pay for it.

Client Cost Sharing (ARM 37.85.204 and 37.85.402)



Cost sharing for optometric services is $2.00 per visit.

Cost sharing fees are a set dollar amount per visit, and they are based on the average Medicaid allowed amount for the provider type and rounded to the nearest dollar. There is no cost sharing cap. Do not show cost sharing as a credit on the claim; it is automatically deducted during claims processing and is shown on the remittance advice. Cost sharing for optometric services is $2.00 per visit. Dispensing providers charge Medicaid clients cost sharing only for the dispensing services, not for the services billed and provided by the eyeglass contractor.

The following clients are exempt from cost sharing:

- Clients under 21 years of age.
- Pregnant women (until end of postpartum, which begins on the last day of pregnancy and ends at the end of the month in which 60 days have passed).
- Inpatients in a hospital, skilled nursing facility, intermediate care facility or other medical institution if the client is required to spend all but their personal needs allowance on the cost of care.
- Medicaid clients who also have Medicare or another insurance are exempt from cost sharing only when the service is allowed by Medicare or paid by the other insurance, and Medicaid is the secondary payer.

Cost sharing may not be charged for the following services:

- Emergencies (see *Definitions*)
- Family planning
- Hospice
- Independent lab and x-ray services
- Personal assistance services
- Home dialysis attendant services
- Home and community based waiver services
- Non-emergency medical transportation services
- Eyeglasses purchased by the Medicaid program under a volume purchasing arrangement
- EPSDT services (see *Covered Services* chapter)

A provider cannot deny services to a Medicaid client because the client cannot pay cost sharing fees at the time services are rendered. However, the client's inability to pay cost sharing fees when services are rendered does not lessen the client's obligation. If a provider has a policy on collecting delinquent payment from non-Medicaid clients, that same policy may be used for Medicaid clients. A provider may sever the relationship with a client who has unpaid cost sharing obligation, as

long as a consistent policy is followed with Medicaid and non-Medicaid clients. Once the relationship is severed, with prior notice to the client either verbally or in writing, the provider may refuse to serve the client.

Usual and Customary Charge (ARM 37.85.406)

Providers should bill Medicaid their usual and customary charge for each service; that is, the same charge that is made to other payers for that service.

When Clients Have Other Insurance

If a Medicaid client is also covered by Medicare, has other insurance, or some other third party is responsible for the cost of the client's health care, see the *Coordination of Benefits* chapter in this manual.

Billing for Retroactively Eligible Clients

When a client becomes retroactively eligible for Medicaid, the provider has 12 months from the date retroactive eligibility was determined to bill for those services. When submitting claims for retroactively eligible clients, attach a copy of the FA-455 (Eligibility determination letter) to the claim if the date of service is more than 12 months earlier than the date the claim is submitted.

When a provider chooses to accept the client from the date retroactive eligibility was effective, and the client has made a full or partial payment for services, the provider must refund the client's payment for the service(s) and bill Medicaid for the service(s).

For more information on retroactive eligibility, see the *Client Eligibility and Responsibilities* chapter in the *General Information For Providers* manual.

Place of Service

Place of service must be entered correctly on each line. Medicaid typically reduces payment for services provided in hospitals and ambulatory surgical centers since these facilities typically bill Medicaid separately for facility charges.

Multiple Visits on Same Date

Medicaid generally covers only one dispensing fee per client per day, unless two pairs of single vision eyeglasses are dispensed (distance/near).

When a client requires additional visits on the same day, use a modifier to describe the reason for multiple visits. When a modifier is not appropriate for the situation, attach documentation of medical necessity to the claim, and submit it to the optometric program officer (see *Key Contacts*).

Coding

Always refer to the long descriptions in coding books.

Standard use of medical coding conventions is required when billing Medicaid. Provider Relations or the Department cannot suggest specific codes to be used in billing for services. For coding assistance and resources, see the table of Coding Resources on the following page. The following suggestions may help reduce coding errors and unnecessary claim denials:

- Use current CPT-4, HCPCS Level II, and ICD-9-CM coding books.
- Always read the complete description and guidelines in the coding books. Relying on short descriptions can result in inappropriate billing.
- Attend classes on coding offered by certified coding specialists.
- Follow CPT-4 guidelines on the difference between a new patient and an established patient.
- Bill for the appropriate level of service provided. For example, the CPT-4 coding book contains detailed descriptions and examples of what differentiates a level 1 established patient office visit (99211) from a level 4 office visit (99214).
- Services covered within "global periods" for certain CPT-4 procedures are not paid separately and must not be billed separately. Most surgical and some medical procedures include routine care before and after the procedure. Medicaid fee schedules show the global period for each CPT-4 service.
- Use the correct number of units on CMS-1500 claims. In general, Medicaid follows the definitions in the CPT-4 and HCPCS Level II coding manuals. Unless otherwise specified, one unit equals one visit or one procedure. For specific codes, however, one unit may be 15 minutes. Always check the long text of the code description.
- CPT codes that are billed based on the amount of time spent with the client must be billed with the code that is closest to the time spent. For example, a provider spends 60 minutes with the client. The code choices are 45 to 50 minutes or 76 to 80 minutes. The provider must bill the code for 45 to 50 minutes.

Coding Resources

Please note that the Department does not endorse the products of any particular publisher.

Resource	Description	Contact
ICD-9-CM	• ICD-9-CM diagnosis and procedure codes definitions • Updated each October.	Available through various publishers and bookstores American Optometric Association (800) 365-2219
CPT-4	• CPT-4 codes and definitions • Updated each January	American Medical Association (800) 621-8335 www.amapress.com or Medicode (Ingenix) (800) 765-6588 www.medicode.com or www.ingenixonline.com or American Optometric Association (800) 365-2219 www.aoanet.org
HCPCS Level II	• HCPCS Level II codes and definitions • Updated each January and throughout the year	Available through various publishers and bookstores or from CMS at cms.hhs.gov/paymentsystems/hcpcs/2001rel.asp
CPT Assistant	A newsletter on CPT-4 coding issues	American Medical Association (800) 621-8335 www.amapress.com
Miscellaneous resources	Various newsletters and other coding resources.	Medicode (Ingenix) (800) 765-6588 www.medicode.com or www.ingenixonline.com
CCI Policy and Edits Manual	This manual contains Correct Coding Initiative (CCI) policy and edits, which are pairs of CPT-4 or HCPCS Level II codes that are not separately payable except under certain circumstances. The edits are applied to services billed by the same provider for the same client on the same date of service.	National Technical Information Service (800) 363-2068 (703) 605-6060 www.ntis.gov/product/correct-coding.htm

Using the Medicaid Fee Schedule

When billing Medicaid, it is important to use the Department's fee schedule for your provider type in conjunction with the detailed coding descriptions listed in the current CPT-4 and HCPCS Level II coding books. In addition to covered services and payment rates, fee schedules often contain helpful information such as global periods, if multiple surgery guidelines apply, if the procedure can be done bilaterally, if an assistant, co-surgeon, or team is allowed for the procedure, if the code is separately billable, if prior authorization is required, and more. Depart-

ment fee schedules are updated each January and July. Current fee schedules are available on the *Provider Information* website (see *Key Contacts*). For disk or hardcopy, contact Provider Relations (see *Key Contacts*).

Using Modifiers

- Review the guidelines for using modifiers in the most current CPT-4, HCPCS Level II, or other helpful resources.
- Always read the complete description for each modifier; some modifiers are described in the CPT-4 manual while others are in the HCPCS Level II book.
- The Medicaid claims processing system recognizes only two pricing modifiers and one informational modifier per claim line. Providers are asked to place any modifiers that affect pricing in the first two modifier fields.
- When billing with modifier 50 for bilateral services, put all information on one line with one unit. You do not need to use modifiers for left and right, and do not bill on separate lines. For example, a bilateral close tear duct opening procedure would be billed like this:
- Check the fee schedule to see if Medicaid allows the use of the following modifiers for a particular code: bilateral (50), multiple procedures (51), co-surgery (62), assistant at surgery (80, 81, 82, AS), and team surgery (66).

24. A						B	C	D	E	F	G	H	I	J	K
DATE(S) OF SERVICE From			To			Place of Service	Type of Service	PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances) CPT/HCPCS | MODIFIER	DIAGNOSIS CODE	$ CHARGES	DAYS OR UNITS	EPSDT Family Plan	EMG	COB	RESERVED FOR LOCAL USE
MM	DD YY	MM	DD	YY											
1 02	23 03	02	23	03		11		68761 | 50	1	250 00	1					

Billing Tips for Specific Services

Bundled services

Certain services with CPT-4 or HCPCS codes (eg., tear duct plugs) are covered by Medicaid but have a fee of zero. This means that the service is typically "bundled" with an office visit or other service. Since the bundled service is covered by Medicaid, providers may not bill the client separately for it.

Contact lenses

When billing Medicaid for contact lenses, include the prior authorization number on the claim (field 23 of the CMS-1500 form).

Eye exams

- A client may be eligible for an eye exam before the specified time limit expires if he or she meets the criteria described in the *Covered Services* chapter, *Eye exams* section of this manual. In this case, enter the reason for the exam on the claim (box 19 of the CMS-1500 claim form).
- Medicare does not cover eye refraction (92015) but instructs providers to report this service as a separate line item from the other service(s) per-

formed. Medicaid covers this procedure, so providers can bill for the eye exam and the refraction.

- Children (age 20 and under for Medicaid or 18 and under for CHIP) may receive an additional exam before the 365-day limit has passed if they have had at least a one line acuity change resulting in prescribing replacement lenses that meet the criteria in the *Eyeglass services* section of the *Covered Services* chapter in this manual. In this case, providers may bill Medicaid for the exam using EPSDT indicator 1 on the claim (field 24h on the CMS-2500 form). See the *Completing a Claim* chapter in this manual.

Eyeglass services

- Adult clients (ages 21 and older) may receive new lenses before the 730-day limit has passed if they meet the criteria described the *Eyeglass services* section of the *Covered Services* chapter in this manual. In this case, providers may bill Medicaid for a dispensing fee for new lens(es) using modifiers 52 and U4 with the dispensing fee procedure code. Adult recipients may be eligible for replacement lenses 12 months after the initial dispensing of contract eyeglasses ***if*** the lenses are broken or unusable.
- Children (age 20 and under for Medicaid or 18 and under for CHIP) may receive new lenses before the 365-day limit has passed if they meet the criteria in the *Eyeglass services* section of the *Covered Services* chapter in this manual. In this case, providers may bill Medicaid for a dispensing fee for new lens(es) using EPSDT indicator 1 on the claim (field 24H of the CMS-1500 claim form).
- If the adult Medicaid client (age 21 and over) is not eligible for lens(es) and/or frame within the 730-day period *(*see *Covered Services* chapter, *Eyeglass services*) the dispensing provider may not bill Medicaid for a dispensing fee. If the client chooses to purchase eyeglasses privately, the provider may bill the Medicaid client for dispensing services and eyeglass materials.
- The eyeglass contractor will bill Medicaid for the laboratory and material costs for lenses and frames.
- Please bill CHIP for eyeglass services and BlueCHIP for optometric services.

Frame services

- When the Medicaid client uses an existing frame, the dispensing provider bills Medicaid for dispensing services, lenses only.
- Providers may not charge a dispensing fee for minor frame repairs that they provide themselves.
- If a client that is covered by Medicare and Medicaid chooses a frame outside the Medicaid contract, the provider cannot bill Medicaid for the dispensing fee. All charges must be billed to Medicare and the client.

Lens add-ons

The eyeglass contractor bills the dispensing provider their usual and customary charge for any lens style, lens material, tint, coating lens enhancement (polished edge, etc.) not covered by Medicaid (see *Covered Services*, *Lens add-ons*). It is the dispensing provider's responsibility to bill the Medicaid client for these items. Do not bill Medicaid.

For example, FT7x35 Trifocal is billed to the dispensing provider at the contractor's usual and customary price, not at a price which would reflect the difference between the contract price for 7x28, and the usual and customary 7x35 price.

For FT 28 CR-39 with polished edges, only the polished edge price is billed to the dispensing provider at the contractor's usual and customary charge.

Replacement lenses and frames

If a client has selected to use an existing frame, and the existing frame breaks after lenses were dispensed to the client, Medicaid will not cover new lenses. The Medicaid client may privately pay for new lenses or select a contract frame that the existing lenses will fit into. If a contract frame is selected, the dispensing provider may bill Medicaid for dispensing services, frame only.

Submitting Electronic Claims

Professional and institutional claims submitted electronically are referred to as ANSI ASC X12N 837 transactions. Providers who submit claims electronically experience fewer errors and quicker payment. Claims may be submitted electronically by the following methods:

- ***ACS field software WINASAP 2003.*** ACS makes available this free software, which providers can use to create and submit claims to Montana Medicaid, MHSP, and CHIP (dental and eyeglasses only). It does not support submissions to Medicare or other payers. This software creates an 837 transaction, but does not accept an 835 (electronic RA) transaction back from the Department. The software can be downloaded directly from the ACS EDI Gateway website. For more information on WINASAP 2003, visit the ACS EDI Gateway website, or call the number listed in the *Key Contacts* section of this manual.
- ***ACS clearinghouse.*** Providers can send claims to the ACS clearinghouse (ACS EDI Gateway) in X12 837 format using a dial-up connection. Electronic submitters are required to certify their 837 transactions as HIPAA-compliant before sending their transactions through the ACS clearinghouse. EDIFECS certifies the 837 HIPAA transactions at no cost to the provider. EDIFECS certification is completed through ACS EDI Gateway. For more information on using the ACS clearinghouse, contact the EDI Technical Help Desk (see *Key Contacts*).

- ***Clearinghouse.*** Providers can contract with a clearinghouse so that the provider can send the claim to the clearinghouse in whatever format the clearinghouse accepts. The provider's clearinghouse then sends the claim to the ACS clearinghouse in the X12 837 format. The provider's clearinghouse also needs to have their 837 transactions certified through EDIFECS before submitting claims to the ACS clearinghouse. EDIFECS certification is completed through ACS EDI Gateway.

Providers should be familiar with the *Implementation Guides* that describe federal rules and regulations and provide instructions on preparing electronic transactions. These guides are available from the Washington Publishing Company (see *Key Contacts*). *Companion Guides* are used in conjunction with *Implementation Guides* and provide Montana-specific information for sending and receiving electronic transactions. They are available on the ACS EDI Gateway website (see *Key Contacts*).

Billing Electronically with Paper Attachments

When submitting claims that require additional supporting documentation, the *Attachment Control Number* field must be populated with an identifier. Identifier formats can be designed by software vendors or clearinghouses, but the preferred method is the provider's Medicaid ID number followed by the client's ID number and the date of service, each separated by a dash:

9999999	-	**888888888**	-	**11182003**
Medicaid Provider ID		Client ID Number		Date of Service (mmddyyyy)

The supporting documentation must be submitted with a paperwork attachment coversheet (located on the Provider Information website and in *Appendix A: Forms*). The number in the paper *Attachment Control Number* field must match the number on the cover sheet. For more information on attachment control numbers and submitting electronic claims, see the *Companion Guides* located on the ACS EDI website (see *Key Contacts*).

Submitting Paper Claims

For instructions on completing a paper claim, see the *Completing a Claim* chapter in this manual. Unless otherwise stated, all paper claims must be mailed to:

Claims Processing
P.O. Box 8000
Helena, MT 59604

Claim Inquiries

The *Provider Information* website contains billing instructions, manuals, notices, fee schedules, answers to commonly-asked questions and much more (see *Key Contacts*). The information available may be downloaded and shared with others

in your office. If you cannot find answers to your questions on the website, or if you have questions on a specific claim, contact Provider Relations (see *Key Contacts*).

If you prefer to communicate with Provider Relations in writing, use the *Montana Medicaid Claim Inquiry* form in *Appendix A.* Complete the top portion of the form with the provider's name and address.

Provider Relations will respond to the inquiry within 7 to 10 days. The response will include the status of the claim: paid (date paid), denied (date denied), or in process. Denied claims will include an explanation of the denial and steps to follow for payment (if the claim is payable).

The Most Common Billing Errors and How to Avoid Them

Paper claims are often returned to the provider before they can be processed, and many other claims (both paper and electronic) are denied. To avoid unnecessary returns and denials, double check each claim to confirm the following items are included and accurate.

Common Billing Errors

Reasons for Return or Denial	How to Prevent Returned or Denied Claims
Medicaid provider number missing or invalid	The provider number is a 7-digit number assigned to the provider during Medicaid enrollment. Verify the correct **Medicaid** provider number is on the claim.
Authorized signature missing	Each claim must have an authorized signature belonging to the provider, billing clerk, or office personnel. The signature may be typed, stamped, or hand-written.
Signature date missing	Each claim must have a signature date.
Incorrect claim form used	The claim must be the correct form for the provider type. Services covered in this manual require a CMS-1500 claim form (or electronic Professional claim).
Information on claim form not legible	Information on the claim form must be legible. Use dark ink and center the information in the field. Information must not be obscured by lines.
Recipient number not on file, or recipient was not eligible on date of service	Before providing services to the client: • View the client's ID card at each visit. Medicaid eligibility may change monthly. • Verify client eligibility by using one of the methods described in the *Client Eligibility and Responsibilities* chapter of the *General Information For Providers* manual.

Common Billing Errors (continued)

Reasons for Return or Denial	How to Prevent Returned or Denied Claims
Duplicate claim	• Please check all remittance advices (RAs) for previously submitted claims before resubmitting. • When making changes to previously paid claims, submit an adjustment form rather than a new claim (see *Remittance Advices and Adjustments* in this manual). • Please allow 45 days for the Medicare/Medicaid Part B crossover claim to appear on the RA before submitting the claim directly to Medicaid.
Medicare Part B crossover claims submitted before Medicare's 45-day crossover limit	Claims that cross over between Medicare Part B and Medicaid should not be billed on paper to Medicaid until 45 days after the Medicare Part B paid date. These claims will be returned to the provider.
Prior authorization number is missing	• Prior authorization (PA) is required for certain services, and the PA number must be on the claim (see the *PASSPORT and Prior Authorization* chapter in this manual). • Mental Health Services Plan (MHSP) claims must be billed and services performed during the prior authorization span. The claim will be denied if it is not billed according to the spans on the authorization. See the *Mental Health Services Plan* manual.
TPL on file and no credit amount on claim	• If the client has any other insurance (or Medicare), bill the other carrier before Medicaid. See *Coordination of Benefits* in this manual. • If the client's TPL coverage has changed, providers must notify the TPL unit (see *Key Contacts*) before submitting a claim.
Claim past 365-day filing limit	• The Claims Processing Unit must receive all clean claims and adjustments within the timely filing limits described in this chapter. • To ensure timely processing, claims and adjustments must be mailed to Claims Processing at the address shown in *Key Contacts*.
Missing Medicare EOMB	All Medicare crossover claims on CMS-1500 forms must have an Explanation of Medicare Benefits (EOMB) attached, and be billed to Medicaid on paper.
Provider is not eligible during dates of services, or provider number terminated	• Out-of-state providers must update enrollment early to avoid denials. If enrollment has lapsed, claims submitted with a date of service after the expiration date will be denied until the provider updates his or her enrollment. • New providers cannot bill for services provided before Medicaid enrollment begins. • If a provider is terminated from the Medicaid program, claims submitted with a date of service after the termination date will be denied.

Common Billing Errors (continued)

Reasons for Return or Denial	How to Prevent Returned or Denied Claims
Type of service/procedure is not allowed for provider type	• Provider is not allowed to perform the service, or type of service is invalid. • Verify the procedure code is correct using current HCPCS and CPT-4 billing manual. • Check the Medicaid fee schedule to verify the procedure code is valid for your provider type.

Other Programs

The billing procedures for eyeglass services apply to the Children's Health Insurance Plan (CHIP). The billing procedures for eye exams do not apply to CHIP because optometric services are covered by the BlueCHIP Plan of Blue Cross and Blue Shield of Montana (see *Key Contacts*).

These billing procedures do not apply to the Mental Health Services Plan (MHSP). The MHSP manual is available on the *Provider Information* website (see *Key Contacts*).

Completing a Claim Form

The services described in this manual are billed either electronically on a Professional claim or on a paper CMS-1500 claim form. Claims submitted with all of the necessary information are referred to as "clean" and are usually paid in a timely manner (see the *Billing Procedure*s chapter in this manual).

Claims are completed differently for the different types of coverage a client has. This chapter includes instructions and a sample claim for each of the following scenarios:

- Client has Medicaid coverage only
- Client has Medicaid and Medicare coverage
- Client has Medicaid and third party liability coverage
- Client has Medicaid, Medicare, and third party liability coverage
- Client has Medicaid, Medicare, and Medicare supplement coverage

When completing a claim, remember the following:

- Required fields are indicated by "*".
- Fields that are required if the information is applicable to the situation or client are indicated by "**".
- Field 24h, *EPSDT/family planning*, is used as an indicator to specify additional details for certain clients or services. The following are accepted codes:

EPSDT/Family Planning Indicators

Code	Client/Service	Purpose
1	EPSDT	This indicator is used when the client is under age 21
2	Family planning	This indicator is used when providing family planning services
3	EPSDT and family planning	This indicator is used when the client is under age 21 and is receiving family planning services
4	Pregnancy (any service provided to a pregnant woman)	This indicator is used when providing services to pregnant women
6	Nursing facility client	This indicator is used when providing services to nursing facility residents

- Unless otherwise stated, all paper claims must be mailed to the following address:

  Claims Processing Unit
  P.O. Box 8000
  Helena, MT 59604

Client Has Medicaid Coverage Only

Field #	Field Title	Instructions
1	Program	Check Medicaid.
1a	Insured's ID number	Leave this field blank for Medicaid only claims.
2*	Patient's name	Enter the client's name as it appears on the Medicaid ID card.
3	Patient's birth date and sex	Client's birth date in month/day/year format. Check male or female box.
5	Patient's address	Client's address.
10	Is patient's condition related to:	Check "Yes" or "No" to indicate whether employment, auto liability, or other accident involvement applies to one or more of the services described in field 24. If you answered "yes" to any of these, enter the two-letter state abbreviation where the accident occurred on the "Place" line.
10d*	Reserved for local use	Enter the client's Medicaid ID number as it appears on their ID card.
11d*	Is there another health benefit plan?	Enter "No". If "Yes", follow claim instructions for appropriate coverage later in this chapter.
14	Date of current illness, injury, pregnancy	Enter date in month/day/year format. This field is optional for Medicaid only claims.
16	Dates patient unable to work in current occupation	If applicable, enter date in month/day/year format. This field is optional for Medicaid only claims.
17	Name of referring physician	Enter the name of the referring physician. For PASSPORT clients, the name of the client's PASSPORT provider goes here.
17a	ID number of referring physician	Enter the client's PASSPORT provider's PASSPORT ID number.
18	Hospitalization dates related to current service	Enter dates if the medical service is furnished as a result of, or subsequent to, a related hospitalization. This field is optional for Medicaid only claims.
19	Reserved for local use	This field is used for any special messages regarding the claim or client.
20	Outside lab?	Check "No". Medicaid requires all lab tests to be billed directly by the provider who performed them.
21*	Diagnosis or nature of illness or injury	Enter the appropriate ICD-9-CM diagnosis codes. Enter up to four codes in priority order (primary, secondary, etc.).
23**	Prior authorization number	If the service requires prior authorization (PA), enter the PA number you received for this service.
24a*	Date(s) of service	Enter date(s) of service for each procedure, service, or supply.
24b*	Place of service	Enter the appropriate two-digit place of service (see *Appendix B*).
24c*	Type of service	Enter Montana's type of service code: Nursing facilities are "9", and all others are "0" (zero).
24d*	Procedure, service, or supplies	Enter the appropriate CPT-4 or HCPCS code for the procedure, service, or supply. When applicable, enter the appropriate CPT-4/HCPCS modifier. Medicaid allows up to three modifiers per procedure code.
24e*	Diagnosis code	Enter the corresponding diagnosis code **reference number** (1, 2, 3 or 4) from field 21 (do not enter the diagnosis code). Any combination of applicable diagnosis reference numbers may be listed on one line.
24f*	Charges	Enter your usual and customary charges (or the Department-designated charges) for the procedure(s) on this line.
24g*	Days or units	Enter the number of units or days for the procedure and date(s) of service billed on this line (see *Billing Procedures*, *Coding* for additional tips on days/units). Anesthesia providers must bill using minutes.
24h**	EPSDT/family planning	If applicable, enter the appropriate code for the client/service: 1, 2, 3, 4 or 6 (see complete description in the *EPSDT/Family Planning Indicators* table earlier in this chapter).
24i**	EMG (Emergency)	Enter an "X" if this service was rendered in a hospital emergency room to override Medicaid copay.
28*	Total charge	Enter the sum of all charges billed in field 24f.
29	Amount paid	Leave blank or enter $0.00. Do not report any client copay or Medicaid payment amounts on this form.
30	Balance due	Enter the balance due as recorded in field 28.
31*	Signature and date	This field must contain an authorized signature and date, which is either hand signed, stamped, or computer generated.
32	Name and address of facility	Enter the name and address of the person, organization, or facility performing the services if other than the client's home or physician's office.
33*	Physician's, supplier's billing name, address, phone number	Enter the name, address, phone number and Montana Medicaid provider number (not UPIN) of the physician or supplier who furnished service.

* = Required Field ** = Required if applicable

Client Has Medicaid Coverage Only

APPROVED OMB-0938-0008

For Medicaid use. Do not write in this area.

CARRIER

PICA

HEALTH INSURANCE CLAIM FORM

PICA

PATIENT AND INSURED INFORMATION

1. MEDICARE ☐ (Medicare #) MEDICAID ☒ (Medicaid #) CHAMPUS ☐ (Sponsor's SSN) CHAMPVA ☐ (VA File #) GROUP HEALTH PLAN ☐ (SSN or ID) FECA BLK LUNG ☐ (SSN) OTHER ☐ (ID)

1a. INSURED'S I.D. NUMBER (FOR PROGRAM IN ITEM 1)

2. PATIENT'S NAME (Last Name, First Name, Middle Initial): Smith, Chuckie L.

3. PATIENT'S BIRTH DATE MM DD YY: 04 28 91 SEX M ☒ F ☐

4. INSURED'S NAME (Last Name, First Name, Middle Initial)

5. PATIENT'S ADDRESS (No., Street): 123 Anystreet #1

6. PATIENT RELATIONSHIP TO INSURED: Self ☒ Spouse ☐ Child ☐ Other ☐

7. INSURED'S ADDRESS (No., Street)

CITY: Anytown STATE: MT

8. PATIENT STATUS: Single ☒ Married ☐ Other ☐

CITY STATE

ZIP CODE: 59999 TELEPHONE (Include Area Code): (406) 555-5555

Employed ☐ Full-Time Student ☐ Part-Time Student ☐

ZIP CODE TELEPHONE (INCLUDE AREA CODE) ( )

9. OTHER INSURED'S NAME (Last Name, First Name, Middle Initial)

10. IS PATIENT'S CONDITION RELATED TO:

11. INSURED'S POLICY GROUP OR FECA NUMBER

a. OTHER INSURED'S POLICY OR GROUP NUMBER

a. EMPLOYMENT? (CURRENT OR PREVIOUS) YES ☐ NO ☒

a. INSURED'S DATE OF BIRTH MM DD YY SEX M ☐ F ☐

b. OTHER INSURED'S DATE OF BIRTH MM DD YY SEX M ☐ F ☐

b. AUTO ACCIDENT? YES ☐ NO ☒ PLACE (State)

b. EMPLOYER'S NAME OR SCHOOL NAME

c. EMPLOYER'S NAME OR SCHOOL NAME

c. OTHER ACCIDENT? YES ☐ NO ☒

c. INSURANCE PLAN NAME OR PROGRAM NAME

d. INSURANCE PLAN NAME OR PROGRAM NAME

10d. RESERVED FOR LOCAL USE: 999999999

d. IS THERE ANOTHER HEALTH BENEFIT PLAN? YES ☐ NO ☒ ***If yes***, return to and complete item 9 a-d.

READ BACK OF FORM BEFORE COMPLETING & SIGNING THIS FORM.

12. PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE I authorize the release of any medical or other information necessary to process this claim. I also request payment of government benefits either to myself or to the party who accepts assignment below.

SIGNED _____ DATE _____

13. INSURED'S OR AUTHORIZED PERSON'S SIGNATURE I authorize payment of medical benefits to the undersigned physician or supplier for services described below.

SIGNED _____

PHYSICIAN OR SUPPLIER INFORMATION

14. DATE OF CURRENT: MM DD YY ILLNESS (First symptom) OR INJURY (Accident) OR PREGNANCY(LMP)

15. IF PATIENT HAS HAD SAME OR SIMILAR ILLNESS. GIVE FIRST DATE MM DD YY

16. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION MM DD YY FROM TO MM DD YY

17. NAME OF REFERRING PHYSICIAN OR OTHER SOURCE

17a. I.D. NUMBER OF REFERRING PHYSICIAN

18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES MM DD YY FROM TO MM DD YY

19. RESERVED FOR LOCAL USE

20. OUTSIDE LAB? YES ☐ NO ☒ $ CHARGES

21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY. (RELATE ITEMS 1,2,3 OR 4 TO ITEM 24E BY LINE)

1. 367.9 3. ____.__

2. ____.__ 4. ____.__

22. MEDICAID RESUBMISSION CODE ORIGINAL REF. NO.

23. PRIOR AUTHORIZATION NUMBER

24. A DATE(S) OF SERVICE From MM DD YY	To MM DD YY	B Place of Service	C Type of Service	D PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances) CPT/HCPCS	MODIFIER	E DIAGNOSIS CODE	F $ CHARGES	G DAYS OR UNITS	H EPSDT Family Plan	I EMG	J COB	K RESERVED FOR LOCAL USE
1 03 18 03		11	0	92004		1	130 00	1				
2 03 18 03		11	0	92015		1	55 00	1				
3												
4												
5												
6												

25. FEDERAL TAX I.D. NUMBER SSN ☐ EIN ☒: 99-9999999

26. PATIENT'S ACCOUNT NO.: 99999

27. ACCEPT ASSIGNMENT? (For govt. claims, see back) YES ☒ NO ☐

28. TOTAL CHARGE: $ 185 00

29. AMOUNT PAID: $ 0 00

30. BALANCE DUE: $ 185 00

31. SIGNATURE OF PHYSICIAN OR SUPPLIER INCLUDING DEGREES OR CREDENTIALS (I certify that the statements on the reverse apply to this bill and are made a part thereof.)

Pierre Oeil, OD 03/20/03

SIGNED DATE

32. NAME AND ADDRESS OF FACILITY WHERE SERVICES WERE RENDERED (If other than home or office)

The Vision Center
12345 Helena Ave.
Anytown, MT 59999

33. PHYSICIAN'S, SUPPLIER'S BILLING NAME, ADDRESS, ZIP CODE & PHONE #

The Vision Center
P.O. Box 999
Anytown, MT 59999

PIN# 0000099999 GRP# (406) 555-5555

(APPROVED BY AMA COUNCIL ON MEDICAL SERVICE 8/88) ***PLEASE PRINT OR TYPE*** FORM HCFA-1500 (12-90), FORM RRB-1500, FORM OWCP-1500

Client Has Medicaid and Medicare Coverage

Field #	Field Title	Instructions
1	Program	Check Medicaid.
1a*	Insured's ID number	Enter the client's Medicare ID number.
2*	Patient's name	Enter the client's name as it appears on the Medicaid ID card.
3	Patient's birth date and sex	Client's birth date in month/day/year format. Check male or female box.
4	Insured's name	Enter the name of the insured or "SAME".
5	Patient's address	Client's address.
7	Insured's address	Enter the insured's address and telephone number or "SAME".
10	Is patient's condition related to:	Check "Yes" or "No" to indicate whether employment, auto liability, or other accident involvement applies to one or more of the services described in field 24. If you answered "yes" to any of these, enter the two-letter state abbreviation where the accident occurred on the "Place" line.
10d*	Reserved for local use	Enter the client's Medicaid ID number as it appears on their ID card.
11	Insured's policy group	This field should be blank.
11c	Insurance plan or program	This field should be blank.
11d*	Is there another health benefit plan?	Check "NO".
14	Date of current illness, injury, pregnancy	Enter date in month/day/year format.
16	Dates patient unable to work in current occupation	If applicable, enter date in month/day/year format.
17	Name of referring physician	Enter the name of the referring physician. For PASSPORT clients, the name of the client's PASSPORT provider goes here.
17a	ID number of referring physician	Enter the client's PASSPORT provider's PASSPORT ID number.
18	Hospitalization dates related to current service	Enter dates if the medical service is furnished as a result of, or subsequent to, a related hospitalization.
19	Reserved for local use	This field is used for any special messages regarding the claim or client.
20	Outside lab?	Check "No". Medicaid requires all lab tests to be billed directly by the provider who performed them.
21*	Diagnosis or nature of illness or injury	Enter the appropriate ICD-9-CM diagnosis codes. Enter up to four codes in priority order (primary, secondary, etc.).
23**	Prior authorization number	If the service requires prior authorization (PA), enter the PA number you received for this service.
24a*	Date(s) of service	Enter date(s) of service for each procedure, service, or supply.
24b*	Place of service	Enter the appropriate two-digit place of service (see *Appendix B*).
24c*	Type of service	Enter Montana's type of service code: Nursing facilities are "9", and all others are "0" (zero).
24d*	Procedure, service, or supplies	Enter the appropriate CPT-4 or HCPCS code for the procedure, service, or supply. When applicable, enter appropriate modifiers. Medicaid recognizes two pricing and one informational modifier per code.
24e*	Diagnosis code	Enter the corresponding diagnosis code **reference number** (1, 2, 3 or 4) from field 21 (do not enter the diagnosis code). Any combination of applicable diagnosis reference numbers may be listed on one line.
24f*	Charges	Enter your usual and customary charges (or the Department-designated charges) for the procedure(s) on this line.
24g*	Days or units	Enter the number of units or days for the procedure and date(s) of service billed on this line (see *Billing Procedures*, *Coding* for additional tips on days/units). Anesthesia providers must bill using minutes.
24h**	EPSDT/family planning	If applicable, enter the appropriate code for the client/service: 1, 2, 3, 4 or 6 (see complete description in the *EPSDT/Family Planning Indicators* table earlier in this chapter).
24i**	EMG (Emergency)	Enter an "X" if this service was rendered in a hospital emergency room to override Medicaid copay.
28	Total charge	Enter the sum of all charges billed in field 24f.
29	Amount paid	Leave this field blank. Do not include any adjustment amounts or coinsurance. The Medicare payment amount will be determined from the EOMB attached to the claim.
30	Balance due	Enter the balance due as listed in field 28.
31*	Signature and date	This field must contain an authorized signature and date, which can be hand signed, stamped, or computer generated.
32	Name and address of facility	Enter the name and address of the person, organization, or facility performing the services if other than the client's home or physician's office.
33*	Physician's, supplier's billing name, address, phone number	Enter the name, address, phone number and Montana Medicaid provider number (not UPIN) of the physician or supplier who furnished service.

* = Required Field ** = Required if applicable

Client Has Medicaid and Medicare Coverage

APPROVED OMB-0938-0008

For Medicaid use. Do not write in this area.

CARRIER

PICA

HEALTH INSURANCE CLAIM FORM

PICA

PATIENT AND INSURED INFORMATION

1. MEDICARE [ ] (Medicare #) MEDICAID [X] (Medicaid #) CHAMPUS [ ] (Sponsor's SSN) CHAMPVA [ ] (VA File #) GROUP HEALTH PLAN [ ] (SSN or ID) FECA BLK LUNG [ ] (SSN) OTHER [ ] (ID)

1a. INSURED'S I.D. NUMBER (FOR PROGRAM IN ITEM 1): 999999999A

2. PATIENT'S NAME (Last Name, First Name, Middle Initial): Jones, Jerry

3. PATIENT'S BIRTH DATE MM DD YY: 02 04 33 SEX M [X] F [ ]

4. INSURED'S NAME (Last Name, First Name, Middle Initial): Same

5. PATIENT'S ADDRESS (No., Street): 4321 Anystreet

6. PATIENT RELATIONSHIP TO INSURED: Self [ ] Spouse [ ] Child [ ] Other [ ]

7. INSURED'S ADDRESS (No., Street): Same

CITY: Anytown STATE: MT

8. PATIENT STATUS: Single [X] Married [ ] Other [ ]

CITY: STATE:

ZIP CODE: 59999 TELEPHONE (Include Area Code): (406) 555-9999

Employed [ ] Full-Time Student [ ] Part-Time Student [ ]

ZIP CODE: TELEPHONE (INCLUDE AREA CODE): ( )

9. OTHER INSURED'S NAME (Last Name, First Name, Middle Initial):

10. IS PATIENT'S CONDITION RELATED TO:

11. INSURED'S POLICY GROUP OR FECA NUMBER:

a. OTHER INSURED'S POLICY OR GROUP NUMBER:

a. EMPLOYMENT? (CURRENT OR PREVIOUS) YES [ ] NO [X]

a. INSURED'S DATE OF BIRTH MM DD YY: SEX M [ ] F [ ]

b. OTHER INSURED'S DATE OF BIRTH MM DD YY: SEX M [ ] F [ ]

b. AUTO ACCIDENT? YES [ ] NO [X] PLACE (State):

b. EMPLOYER'S NAME OR SCHOOL NAME:

c. EMPLOYER'S NAME OR SCHOOL NAME:

c. OTHER ACCIDENT? YES [ ] NO [X]

c. INSURANCE PLAN NAME OR PROGRAM NAME:

d. INSURANCE PLAN NAME OR PROGRAM NAME:

10d. RESERVED FOR LOCAL USE: 999999999

d. IS THERE ANOTHER HEALTH BENEFIT PLAN? YES [ ] NO [X] ***If yes***, return to and complete item 9 a-d.

READ BACK OF FORM BEFORE COMPLETING & SIGNING THIS FORM.

12. PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE I authorize the release of any medical or other information necessary to process this claim. I also request payment of government benefits either to myself or to the party who accepts assignment below.

SIGNED _____ DATE _____

13. INSURED'S OR AUTHORIZED PERSON'S SIGNATURE I authorize payment of medical benefits to the undersigned physician or supplier for services described below.

SIGNED _____

PHYSICIAN OR SUPPLIER INFORMATION

14. DATE OF CURRENT: MM DD YY ILLNESS (First symptom) OR INJURY (Accident) OR PREGNANCY(LMP)

15. IF PATIENT HAS HAD SAME OR SIMILAR ILLNESS. GIVE FIRST DATE MM DD YY

16. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION MM DD YY FROM TO MM DD YY

17. NAME OF REFERRING PHYSICIAN OR OTHER SOURCE

17a. I.D. NUMBER OF REFERRING PHYSICIAN

18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES MM DD YY FROM TO MM DD YY

19. RESERVED FOR LOCAL USE

20. OUTSIDE LAB? YES [ ] NO [X] $ CHARGES

21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY. (RELATE ITEMS 1,2,3 OR 4 TO ITEM 24E BY LINE)

1. 366.16 3. ____.__

2. ____.__ 4. ____.__

22. MEDICAID RESUBMISSION CODE ORIGINAL REF. NO.

23. PRIOR AUTHORIZATION NUMBER

24. A DATE(S) OF SERVICE From MM DD YY	To MM DD YY	B Place of Service	C Type of Service	D PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances) CPT/HCPCS	MODIFIER	E DIAGNOSIS CODE	F $ CHARGES	G DAYS OR UNITS	H EPSDT Family Plan	I EMG	J COB	K RESERVED FOR LOCAL USE
1 02 07 03	02 07 03	24	0	66984	54 LT	1	498 33	1				
2												
3												
4												
5												
6												

25. FEDERAL TAX I.D. NUMBER SSN [ ] EIN [X]: 99-9999999

26. PATIENT'S ACCOUNT NO.: 99999999ABC

27. ACCEPT ASSIGNMENT? (For govt. claims, see back) YES [X] NO [ ]

28. TOTAL CHARGE: $ 498 33

29. AMOUNT PAID: $

30. BALANCE DUE: $ 498 33

31. SIGNATURE OF PHYSICIAN OR SUPPLIER INCLUDING DEGREES OR CREDENTIALS (I certify that the statements on the reverse apply to this bill and are made a part thereof.)

Edward Carter, OD 04/15/03

SIGNED DATE

32. NAME AND ADDRESS OF FACILITY WHERE SERVICES WERE RENDERED (If other than home or office)

Anytown Surgicenter
123 Medical Drive
Anytown, MT 59999

33. PHYSICIAN'S, SUPPLIER'S BILLING NAME, ADDRESS, ZIP CODE & PHONE #

A-1 Eye Care
123 Medical Drive
Anytown, MT 59999

PIN# 9999999 GRP# (406) 555-5555

(APPROVED BY AMA COUNCIL ON MEDICAL SERVICE 8/88) ***PLEASE PRINT OR TYPE*** FORM HCFA-1500 (12-90), FORM RRB-1500, FORM OWCP-1500

Client Has Medicaid and Third Party Liability Coverage

Field #	Field Title	Instructions
1	Program	Check Medicaid.
1a*	Insured's ID number	Enter the client's ID number for the primary carrier.
2*	Patient's name	Enter the client's name as it appears on the Medicaid ID card.
3	Patient's birth date and sex	Client's birth date in month/day/year format. Check male or female box.
4	Insured's name	Enter the name of the insured or "SAME".
5	Patient's address	Client's address.
7	Insured's address	Enter the insured's address and telephone number or "SAME".
9 -9d	Other insured's information	Use these fields only if there are two or more third party insurance carriers (not including Medicaid and Medicare).
10	Is patient's condition related to:	Check "Yes" or "No" to indicate whether employment, auto liability, or other accident involvement applies to one or more of the services described in field 24. If you answered "yes" to any of these, enter the two-letter state abbreviation where the accident occurred on the "Place" line.
10d*	Reserved for local use	Enter the client's Medicaid ID number as it appears on their ID card.
11	Insured's policy group	Leave this field blank, or enter the client's ID number for the primary payer.
11c*	Insurance plan or program	Enter the name of the other insurance plan or program (i.e. BlueCross BlueShield, New West, etc.).
11d*	Is there another health benefit plan?	Check "YES".
14	Date of current illness, injury, pregnancy	Enter date in month/day/year format.
16	Dates patient unable to work in current occupation	If applicable, enter date in month/day/year format.
17	Name of referring physician	Enter the name of the referring physician. For PASSPORT clients, the name of the client's PASSPORT provider goes here.
17a	ID number of referring physician	Enter the client's PASSPORT provider's PASSPORT ID number.
18	Hospitalization dates related to current service	Enter dates if the medical service is furnished as a result of, or subsequent to, a related hospitalization.
19	Reserved for local use	This field is used for any special messages regarding the claim or client.
20	Outside lab?	Check "No". Medicaid requires all lab tests to be billed directly by the provider who performed them.
21*	Diagnosis or nature of illness or injury	Enter the appropriate ICD-9-CM diagnosis codes. Enter up to four codes in priority order (primary, secondary, etc.).
23**	Prior authorization number	If the service requires prior authorization (PA), enter the PA number you received for this service.
24a*	Date(s) of service	Enter date(s) of service for each procedure, service, or supply.
24b*	Place of service	Enter the appropriate two-digit place of service (see *Appendix B*).
24c*	Type of service	Enter Montana's type of service code: Nursing facilities are "9", and all others are "0" (zero).
24d*	Procedure, service, or supplies	Enter the appropriate CPT-4 or HCPCS code for the procedure, service, or supply. When applicable, enter appropriate modifiers. Medicaid recognizes two pricing and one informational modifier per code.
24e*	Diagnosis code	Enter the corresponding diagnosis code **reference number** (1, 2, 3 or 4) from field 21 (do not enter the diagnosis code). Any combination of applicable diagnosis reference numbers may be listed on one line.
24f*	Charges	Enter your usual and customary charges (or the Department-designated charges) for the procedure(s) on this line.
24g*	Days or units	Enter the number of units or days for the procedure and date(s) of service billed on this line (see *Billing Procedures, Coding* for additional tips on days/units). Anesthesia providers must bill using minutes.
24h**	EPSDT/family planning	If applicable, enter the appropriate code for the client/service: 1, 2, 3, 4 or 6 (see complete description in the *EPSDT/Family Planning Indicators* table earlier in this chapter).
24i**	EMG (Emergency)	Enter an "X" if this service was rendered in a hospital emergency room to override Medicaid copay.
28*	Total charge	Enter the sum of all charges billed in field 24f.
29*	Amount paid	Enter the amount paid by the other insurance. Do not include any adjustment amounts or coinsurance.
30*	Balance due	Enter the balance due (the amount in field 28 less the amount in field 29).
31*	Signature and date	This field must contain an authorized signature and date, which can be hand signed, stamped, or computer generated.
32	Name and address of facility	Enter the name and address of the person, organization, or facility performing the services if other than the client's home or physician's office.
33*	Physician's, supplier's billing name, address, phone number	Enter the name, address, phone number and Montana Medicaid provider number (not UPIN) of the physician or supplier who furnished service.

* = Required Field ** = Required if applicable

Client Has Medicaid and Third Party Liability Coverage

APPROVED OMB-0938-0008

PLEASE DO NOT STAPLE IN THIS AREA

For Medicaid use. Do not write in this area.

PICA

HEALTH INSURANCE CLAIM FORM

PICA

CARRIER

PATIENT AND INSURED INFORMATION

1. MEDICARE [ ] (Medicare #) MEDICAID [X] (Medicaid #) CHAMPUS [ ] (Sponsor's SSN) CHAMPVA [ ] (VA File #) GROUP HEALTH PLAN [ ] (SSN or ID) FECA BLK LUNG [ ] (SSN) OTHER [ ] (ID)

1a. INSURED'S I.D. NUMBER (FOR PROGRAM IN ITEM 1): 999999999B

2. PATIENT'S NAME (Last Name, First Name, Middle Initial): Jackson, Renee P.

3. PATIENT'S BIRTH DATE MM DD YY: 08 31 80 SEX M [ ] F [X]

4. INSURED'S NAME (Last Name, First Name, Middle Initial): Same

5. PATIENT'S ADDRESS (No., Street): 4321 Anystreet

6. PATIENT RELATIONSHIP TO INSURED: Self [X] Spouse [ ] Child [ ] Other [ ]

7. INSURED'S ADDRESS (No., Street): Same

CITY: Anytown STATE: MT

8. PATIENT STATUS: Single [X] Married [ ] Other [ ]

CITY STATE

ZIP CODE: 59999 TELEPHONE (Include Area Code): (406)999-9999

Employed [ ] Full-Time Student [ ] Part-Time Student [ ]

ZIP CODE TELEPHONE (INCLUDE AREA CODE): ( )

9. OTHER INSURED'S NAME (Last Name, First Name, Middle Initial):

10. IS PATIENT'S CONDITION RELATED TO:

11. INSURED'S POLICY GROUP OR FECA NUMBER: 999999999B

a. OTHER INSURED'S POLICY OR GROUP NUMBER

a. EMPLOYMENT? (CURRENT OR PREVIOUS) [X] YES [ ] NO

a. INSURED'S DATE OF BIRTH MM DD YY SEX M [ ] F [ ]

b. OTHER INSURED'S DATE OF BIRTH MM DD YY SEX M [ ] F [ ]

b. AUTO ACCIDENT? [ ] YES [ ] NO PLACE (State)

b. EMPLOYER'S NAME OR SCHOOL NAME

c. EMPLOYER'S NAME OR SCHOOL NAME

c. OTHER ACCIDENT? [ ] YES [ ] NO

c. INSURANCE PLAN NAME OR PROGRAM NAME: Paywell Insurance

d. INSURANCE PLAN NAME OR PROGRAM NAME

10d. RESERVED FOR LOCAL USE: 999999999

d. IS THERE ANOTHER HEALTH BENEFIT PLAN? [X] YES [ ] NO *If yes*, return to and complete item 9 a-d.

READ BACK OF FORM BEFORE COMPLETING & SIGNING THIS FORM.

12. PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE I authorize the release of any medical or other information necessary to process this claim. I also request payment of government benefits either to myself or to the party who accepts assignment below.

SIGNED _____ DATE _____

13. INSURED'S OR AUTHORIZED PERSON'S SIGNATURE I authorize payment of medical benefits to the undersigned physician or supplier for services described below.

SIGNED _____

PHYSICIAN OR SUPPLIER INFORMATION

14. DATE OF CURRENT: MM DD YY ILLNESS (First symptom) OR INJURY (Accident) OR PREGNANCY(LMP)

15. IF PATIENT HAS HAD SAME OR SIMILAR ILLNESS. GIVE FIRST DATE MM DD YY

16. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION MM DD YY FROM TO MM DD YY

17. NAME OF REFERRING PHYSICIAN OR OTHER SOURCE

17a. I.D. NUMBER OF REFERRING PHYSICIAN

18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES MM DD YY FROM TO MM DD YY

19. RESERVED FOR LOCAL USE

20. OUTSIDE LAB? [ ] YES [X] NO $ CHARGES

21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY. (RELATE ITEMS 1,2,3 OR 4 TO ITEM 24E BY LINE)

1. 362.16 3. _____

2. _____ 4. _____

22. MEDICAID RESUBMISSION CODE ORIGINAL REF. NO.

23. PRIOR AUTHORIZATION NUMBER

24. A DATE(S) OF SERVICE From MM DD YY	To MM DD YY	B Place of Service	C Type of Service	D PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances) CPT/HCPCS	MODIFIER	E DIAGNOSIS CODE	F $ CHARGES	G DAYS OR UNITS	H EPSDT Family Plan	I EMG	J COB	K RESERVED FOR LOCAL USE
1 02 16 03	02 16 03	11	0	92004		1	125 00	1				
2 02 16 03	02 16 03	11	0	92250		1	95 00	1				
3												
4												
5												
6												

25. FEDERAL TAX I.D. NUMBER SSN [ ] EIN [ ]

26. PATIENT'S ACCOUNT NO.

27. ACCEPT ASSIGNMENT? (For govt. claims, see back) [ ] YES [ ] NO

28. TOTAL CHARGE $ 220 00

29. AMOUNT PAID $ 210 00

30. BALANCE DUE $ 10 00

31. SIGNATURE OF PHYSICIAN OR SUPPLIER INCLUDING DEGREES OR CREDENTIALS (I certify that the statements on the reverse apply to this bill and are made a part thereof.)

Bridgette Auge, OD 2/16/03

SIGNED DATE

32. NAME AND ADDRESS OF FACILITY WHERE SERVICES WERE RENDERED (If other than home or office)

Vision Services
25 Medical Drive
Anytown, MT 59999

33. PHYSICIAN'S, SUPPLIER'S BILLING NAME, ADDRESS, ZIP CODE & PHONE #

Vision Services
P.O. Box 999
Anytown, MT 59999

PIN# 999999 GRP# (406) 999-9999

(APPROVED BY AMA COUNCIL ON MEDICAL SERVICE 8/88) ***PLEASE PRINT OR TYPE*** FORM HCFA-1500 (12-90), FORM RRB-1500, FORM OWCP-1500

Client Has Medicaid, Medicare, and Third Party Liability Coverage

Field #	Field Title	Instructions
1	Program	Check Medicaid.
1a*	Insured's ID number	Enter the client's Medicare ID number.
2*	Patient's name	Enter the client's name as it appears on the Medicaid ID card.
3	Patient's birth date and sex	Client's birth date in month/day/year format. Check male or female box.
4	Insured's name	Enter the name of the insured or "SAME".
5	Patient's address	Client's address.
7	Insured's address	Enter the insured's address and telephone number or "SAME".
9 -9d	Other insured's information	Use these fields only if there are two or more third party insurance carriers (not including Medicaid and Medicare).
10	Is patient's condition related to:	Check "Yes" or "No" to indicate whether employment, auto liability, or other accident involvement applies to one or more of the services described in field 24. If you answered "yes" to any of these, enter the two-letter state abbreviation where the accident occurred on the "Place" line.
10d*	Reserved for local use	Enter the client's Medicaid ID number as it appears on their ID card.
11*	Insured's policy group	Enter the client's primary payer (TPL) ID number.
11c*	Insurance plan or program	Enter the name of the primary payer.
11d*	Is there another health benefit plan?	Check "YES".
14	Date of current illness, injury, pregnancy	Enter date in month/day/year format.
16	Dates patient unable to work in current occupation	If applicable, enter date in month/day/year format.
17	Name of referring physician	Enter the name of the referring physician. For PASSPORT clients, the name of the client's PASSPORT provider goes here.
17a	ID number of referring physician	Enter the client's PASSPORT provider's PASSPORT ID number.
18	Hospitalization dates related to current service	Enter dates if the medical service is furnished as a result of, or subsequent to, a related hospitalization.
19	Reserved for local use	This field is used for any special messages regarding the claim or client.
20	Outside lab?	Check "No". Medicaid requires all lab tests to be billed directly by the provider who performed them.
21*	Diagnosis or nature of illness or injury	Enter the appropriate ICD-9-CM diagnosis codes. Enter up to four codes in priority order (primary, secondary, etc.).
23**	Prior authorization number	If the service requires prior authorization (PA), enter the PA number you received for this service.
24a*	Date(s) of service	Enter date(s) of service for each procedure, service, or supply.
24b*	Place of service	Enter the appropriate two-digit place of service (see *Appendix B*).
24c*	Type of service	Enter Montana's type of service code: Nursing facilities are "9", and all others are "0" (zero).
24d*	Procedure, service, or supplies	Enter the appropriate CPT-4 or HCPCS code for the procedure, service, or supply. When applicable, enter appropriate modifiers. Medicaid recognizes two pricing and one informational modifier per code.
24e*	Diagnosis code	Enter the corresponding diagnosis code **reference number** (1, 2, 3 or 4) from field 21 (do not enter the diagnosis code). Any combination of applicable diagnosis reference numbers may be listed on one line.
24f*	Charges	Enter your usual and customary charges (or the Department-designated charges) for the procedure(s) on this line.
24g*	Days or units	Enter the number of units or days for the procedure and date(s) of service billed on this line (see *Billing Procedures*, *Coding* for additional tips on days/units). Anesthesia providers must bill using minutes.
24h**	EPSDT/family planning	If applicable, enter the appropriate code for the client/service: 1, 2, 3, 4 or 6 (see complete description in the *EPSDT/Family Planning Indicators* table earlier in this chapter).
24i**	EMG (Emergency)	Enter an "X" if this service was rendered in a hospital emergency room to override Medicaid copay.
28*	Total charge	Enter the sum of all charges billed in field 24f.
29*	Amount paid	Enter the amount paid by the primary payer (not Medicare). Do not include any adjustment amounts or coinsurance. The Medicare payment amount will be determined from the EOMB attached to the claim.
30*	Balance due	Enter the balance due (the amount in field 28 less the amount in field 29).
31*	Signature and date	This field must contain an authorized signature and date, which can be hand signed, stamped, or computer generated.
32	Name and address of facility	Enter the name and address of the person, organization, or facility performing the services if other than the client's home or physician's office.
33*	Physician's, supplier's billing name, address, phone number	Enter the name, address, phone number and Montana Medicaid provider number (not UPIN) of the physician or supplier who furnished service.

* = Required Field ** = Required if applicable

Client Has Medicaid, Medicare, and Third Party Liability Coverage

APPROVED OMB-0938-0008

PLEASE DO NOT STAPLE IN THIS AREA

For Medicaid use. Do not write in this area.

CARRIER

PICA

HEALTH INSURANCE CLAIM FORM

PICA

PATIENT AND INSURED INFORMATION

1. MEDICARE [ ] (Medicare #) MEDICAID [X] (Medicaid #) CHAMPUS [ ] (Sponsor's SSN) CHAMPVA [ ] (VA File #) GROUP HEALTH PLAN [ ] (SSN or ID) FECA BLK LUNG [ ] (SSN) OTHER [ ] (ID)

1a. INSURED'S I.D. NUMBER (FOR PROGRAM IN ITEM 1): 999999999

2. PATIENT'S NAME (Last Name, First Name, Middle Initial): Olsen, Karen Z.

3. PATIENT'S BIRTH DATE MM DD YY: 11 07 53 SEX M [ ] F [X]

4. INSURED'S NAME (Last Name, First Name, Middle Initial): Same

5. PATIENT'S ADDRESS (No., Street): 98765 Anystreet #2

6. PATIENT RELATIONSHIP TO INSURED: Self [X] Spouse [ ] Child [ ] Other [ ]

7. INSURED'S ADDRESS (No., Street): Same

CITY: Anytown STATE: MT

8. PATIENT STATUS: Single [X] Married [ ] Other [ ] Employed [ ] Full-Time Student [ ] Part-Time Student [ ]

CITY: STATE:

ZIP CODE: 59999 TELEPHONE (Include Area Code): (406) 999-9999

ZIP CODE: TELEPHONE (INCLUDE AREA CODE): ( )

9. OTHER INSURED'S NAME (Last Name, First Name, Middle Initial):

10. IS PATIENT'S CONDITION RELATED TO:

11. INSURED'S POLICY GROUP OR FECA NUMBER: 999999999A

a. OTHER INSURED'S POLICY OR GROUP NUMBER:

a. EMPLOYMENT? (CURRENT OR PREVIOUS) YES [ ] NO [X]

a. INSURED'S DATE OF BIRTH MM DD YY: SEX M [ ] F [ ]

b. OTHER INSURED'S DATE OF BIRTH MM DD YY: SEX M [ ] F [ ]

b. AUTO ACCIDENT? YES [ ] NO [X] PLACE (State):

b. EMPLOYER'S NAME OR SCHOOL NAME:

c. EMPLOYER'S NAME OR SCHOOL NAME:

c. OTHER ACCIDENT? YES [ ] NO [X]

c. INSURANCE PLAN NAME OR PROGRAM NAME: Paywell Insurance

d. INSURANCE PLAN NAME OR PROGRAM NAME:

10d. RESERVED FOR LOCAL USE: 999999999

d. IS THERE ANOTHER HEALTH BENEFIT PLAN? YES [X] NO [ ] *If yes*, return to and complete item 9 a-d.

READ BACK OF FORM BEFORE COMPLETING & SIGNING THIS FORM.

12. PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE I authorize the release of any medical or other information necessary to process this claim. I also request payment of government benefits either to myself or to the party who accepts assignment below.

SIGNED _____ DATE _____

13. INSURED'S OR AUTHORIZED PERSON'S SIGNATURE I authorize payment of medical benefits to the undersigned physician or supplier for services described below.

SIGNED _____

PHYSICIAN OR SUPPLIER INFORMATION

14. DATE OF CURRENT: MM DD YY ILLNESS (First symptom) OR INJURY (Accident) OR PREGNANCY(LMP)

15. IF PATIENT HAS HAD SAME OR SIMILAR ILLNESS. GIVE FIRST DATE MM DD YY

16. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION MM DD YY FROM TO MM DD YY

17. NAME OF REFERRING PHYSICIAN OR OTHER SOURCE

17a. I.D. NUMBER OF REFERRING PHYSICIAN

18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES MM DD YY FROM TO MM DD YY

19. RESERVED FOR LOCAL USE

20. OUTSIDE LAB? YES [ ] NO [X] $ CHARGES

21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY. (RELATE ITEMS 1,2,3 OR 4 TO ITEM 24E BY LINE)

1. 362.36
2. 366.16
3. 362.15
4. 367.21

22. MEDICAID RESUBMISSION CODE: ORIGINAL REF. NO.

23. PRIOR AUTHORIZATION NUMBER

24. A DATE(S) OF SERVICE From MM DD YY	To MM DD YY	B Place of Service	C Type of Service	D PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances) CPT/HCPCS	MODIFIER	E DIAGNOSIS CODE	F $ CHARGES	G DAYS OR UNITS	H EPSDT Family Plan	I EMG	J COB	K RESERVED FOR LOCAL USE
1 12 20 02	12 20 02	11	0	92004		1	125 00	1				
2 12 20 02	12 20 02	11	0	92250		1	98 00	1				
3												
4												
5												
6												

25. FEDERAL TAX I.D. NUMBER SSN [ ] EIN [X]: 99-9999999

26. PATIENT'S ACCOUNT NO.:

27. ACCEPT ASSIGNMENT? (For govt. claims, see back) YES [X] NO [ ]

28. TOTAL CHARGE: $ 223 00

29. AMOUNT PAID: $ 178 73

30. BALANCE DUE: $ 44 27

31. SIGNATURE OF PHYSICIAN OR SUPPLIER INCLUDING DEGREES OR CREDENTIALS (I certify that the statements on the reverse apply to this bill and are made a part thereof.)

John Ojo, OD 01/31/03

SIGNED DATE

32. NAME AND ADDRESS OF FACILITY WHERE SERVICES WERE RENDERED (If other than home or office)

John Ojo, OD
123 Mountain View
Anytown, MT 59999

33. PHYSICIAN'S, SUPPLIER'S BILLING NAME, ADDRESS, ZIP CODE & PHONE #

John Ojo, OD
P.O. Box 999
Anytown, MT 59999

PIN# 999999 GRP# (406) 999-9999

(APPROVED BY AMA COUNCIL ON MEDICAL SERVICE 8/88) ***PLEASE PRINT OR TYPE*** FORM HCFA-1500 (12-90), FORM RRB-1500, FORM OWCP-1500

Client Has Medicaid, Medicare, and Medicare Supplement Coverage

Field #	Field Title	Instructions
1	Program	Check Medicaid.
1a*	Insured's ID number	Enter the client's Medicare ID number.
2*	Patient's name	Enter the client's name as it appears on the Medicaid ID card.
3	Patient's birth date and sex	Client's birth date in month/day/year format. Check male or female box.
4	Insured's name	Enter the name of the insured or "SAME".
5	Patient's address	Client's address.
7	Insured's address	Enter the insured's address and telephone number or "SAME".
9 -9d	Other insured's information	Use these fields only if there are two or more third party insurance carriers (not including Medicaid and Medicare).
10	Is patient's condition related to:	Check "Yes" or "No" to indicate whether employment, auto liability, or other accident involvement applies to one or more of the services described in field 24. If you answered "yes" to any of these, enter the two-letter state abbreviation where the accident occurred on the "Place" line.
10d*	Reserved for local use	Enter the client's Medicaid ID number as it appears on their ID card.
11*	Insured's policy group	Enter the client's ID number for the primary payer.
11c*	Insurance plan or program	Enter the name of the other insurance plan or program (i.e. BlueCross BlueShield, New West, etc.).
11d*	Is there another health benefit plan?	Check "YES".
14	Date of current illness, injury, pregnancy	Enter date in month/day/year format.
16	Dates patient unable to work in current occupation	If applicable, enter date in month/day/year format.
17	Name of referring physician	Enter the name of the referring physician. For PASSPORT clients, the name of the client's PASSPORT provider goes here.
17a	ID number of referring physician	Enter the client's PASSPORT provider's PASSPORT ID number.
18	Hospitalization dates related to current service	Enter dates if the medical service is furnished as a result of, or subsequent to, a related hospitalization.
19	Reserved for local use	This field is used for any special messages regarding the claim or client.
20	Outside lab?	Check "No". Medicaid requires all lab tests to be billed directly by the provider who performed them.
21*	Diagnosis or nature of illness or injury	Enter the appropriate ICD-9-CM diagnosis codes. Enter up to four codes in priority order (primary, secondary, etc.).
23**	Prior authorization number	If the service requires prior authorization (PA), enter the PA number you received for this service.
24a*	Date(s) of service	Enter date(s) of service for each procedure, service, or supply.
24b*	Place of service	Enter the appropriate two-digit place of service (see *Appendix B*).
24c*	Type of service	Enter Montana's type of service code: Nursing facilities are "9", and all others are "0" (zero).
24d*	Procedure, service, or supplies	If applicable, enter the appropriate CPT-4 or HCPCS code for the procedure, service, or supply. When applicable, enter appropriate modifiers. Medicaid recognizes two pricing and one informational modifier per code.
24e*	Diagnosis code	Enter the corresponding diagnosis code **reference number** (1, 2, 3 or 4) from field 21 (do not enter the diagnosis code). Any combination of applicable diagnosis reference numbers may be listed on one line.
24f*	Charges	Enter your usual and customary charges (or the Department-designated charges) for the procedure(s) on this line.
24g*	Days or units	Enter the number of units or days for the procedure and date(s) of service billed on this line (see *Billing Procedures*, *Coding* for additional tips on days/units). Anesthesia providers must bill using minutes.
24h**	EPSDT/family planning	Enter the appropriate code for the client/service: 1, 2, 3, 4 or 6 (see complete description in the *EPSDT/ Family Planning Indicators* table earlier in this chapter).
24i**	EMG (Emergency)	Enter an "X" if this service was rendered in a hospital emergency room to override Medicaid copay.
28*	Total charge	Enter the sum of all charges billed in field 24f.
29*	Amount paid	Enter the amount paid by the Medicare supplement insurance only. Do not include any adjustment amounts or coinsurance. Medicare payment is determined from the EOMB attached to the claim.
30*	Balance due	Enter balance due (amount in field 28 less the amount in field 29).
31*	Signature and date	This field must contain an authorized signature and date, which can be hand signed, stamped, or computer generated.
32	Name and address of facility	Enter the name and address of the person, organization, or facility performing the services if other than the client's home or physician's office.
33*	Physician's, supplier's billing name, address, phone number	Enter the name, address, phone number and Montana Medicaid provider number (not UPIN) of the physician or supplier who furnished service.

* = Required Field ** = Required if applicable

Client Has Medicaid, Medicare, and Medicare Supplement Coverage

PLEASE DO NOT STAPLE IN THIS AREA

APPROVED OMB-0938-0008

For Medicaid use. Do not write in this area.

CARRIER

PICA

HEALTH INSURANCE CLAIM FORM

PICA

PATIENT AND INSURED INFORMATION

1. MEDICARE [ ] (Medicare #) MEDICAID [X] (Medicaid #) CHAMPUS [ ] (Sponsor's SSN) CHAMPVA [ ] (VA File #) GROUP HEALTH PLAN [ ] (SSN or ID) FECA BLK LUNG [ ] (SSN) OTHER [ ] (ID)

1a. INSURED'S I.D. NUMBER (FOR PROGRAM IN ITEM 1): 999999999A

2. PATIENT'S NAME (Last Name, First Name, Middle Initial): Smith, Georgia P.

3. PATIENT'S BIRTH DATE: 05 13 37 SEX: M [ ] F [X]

4. INSURED'S NAME (Last Name, First Name, Middle Initial): Same

5. PATIENT'S ADDRESS (No., Street): 123 Sun City Road

6. PATIENT RELATIONSHIP TO INSURED: Self [X] Spouse [ ] Child [ ] Other [ ]

7. INSURED'S ADDRESS (No., Street): Same

CITY: Anytown STATE: MT

8. PATIENT STATUS: Single [X] Married [ ] Other [ ]

CITY: STATE:

ZIP CODE: 59999 TELEPHONE (Include Area Code): (406) 555-5555

Employed [ ] Full-Time Student [ ] Part-Time Student [ ]

ZIP CODE: TELEPHONE (INCLUDE AREA CODE): ( )

9. OTHER INSURED'S NAME (Last Name, First Name, Middle Initial):

10. IS PATIENT'S CONDITION RELATED TO:

11. INSURED'S POLICY GROUP OR FECA NUMBER: 999999999B

a. OTHER INSURED'S POLICY OR GROUP NUMBER:

a. EMPLOYMENT? (CURRENT OR PREVIOUS): YES [ ] NO [X]

a. INSURED'S DATE OF BIRTH: SEX: M [ ] F [ ]

b. OTHER INSURED'S DATE OF BIRTH: SEX: M [ ] F [ ]

b. AUTO ACCIDENT? YES [ ] NO [X] PLACE (State):

b. EMPLOYER'S NAME OR SCHOOL NAME:

c. EMPLOYER'S NAME OR SCHOOL NAME:

c. OTHER ACCIDENT? YES [ ] NO [X]

c. INSURANCE PLAN NAME OR PROGRAM NAME: Paywell Supplemental Insurance

d. INSURANCE PLAN NAME OR PROGRAM NAME:

10d. RESERVED FOR LOCAL USE: 999999999

d. IS THERE ANOTHER HEALTH BENEFIT PLAN? YES [X] NO [ ] *If yes*, return to and complete item 9 a-d.

READ BACK OF FORM BEFORE COMPLETING & SIGNING THIS FORM.

12. PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE I authorize the release of any medical or other information necessary to process this claim. I also request payment of government benefits either to myself or to the party who accepts assignment below.

SIGNED _____ DATE _____

13. INSURED'S OR AUTHORIZED PERSON'S SIGNATURE I authorize payment of medical benefits to the undersigned physician or supplier for services described below.

SIGNED _____

PHYSICIAN OR SUPPLIER INFORMATION

14. DATE OF CURRENT: MM DD YY ILLNESS (First symptom) OR INJURY (Accident) OR PREGNANCY(LMP)

15. IF PATIENT HAS HAD SAME OR SIMILAR ILLNESS. GIVE FIRST DATE MM DD YY

16. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION MM DD YY FROM TO MM DD YY

17. NAME OF REFERRING PHYSICIAN OR OTHER SOURCE

17a. I.D. NUMBER OF REFERRING PHYSICIAN

18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES MM DD YY FROM TO MM DD YY

19. RESERVED FOR LOCAL USE

20. OUTSIDE LAB? YES [ ] NO [X] $ CHARGES

21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY. (RELATE ITEMS 1,2,3 OR 4 TO ITEM 24E BY LINE)

1. 366.16 3. ____.__

2. ____.__ 4. ____.__

22. MEDICAID RESUBMISSION CODE: ORIGINAL REF. NO.

23. PRIOR AUTHORIZATION NUMBER

24. A DATE(S) OF SERVICE From MM DD YY	To MM DD YY	B Place of Service	C Type of Service	D PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances) CPT/HCPCS	MODIFIER	E DIAGNOSIS CODE	F $ CHARGES	G DAYS OR UNITS	H EPSDT Family Plan	I EMG	J COB	K RESERVED FOR LOCAL USE
1 12 20 02	12 20 02	11	0	76519		1	120 00	1				
2 12 20 02	12 20 02	11	0	99213		1	65 00	1				
3												
4												
5												
6												

25. FEDERAL TAX I.D. NUMBER: 99-9999999 SSN [ ] EIN [X]

26. PATIENT'S ACCOUNT NO.:

27. ACCEPT ASSIGNMENT? (For govt. claims, see back) YES [X] NO [ ]

28. TOTAL CHARGE: $ 506 00

29. AMOUNT PAID: $ 404 00

30. BALANCE DUE: $ 102 00

31. SIGNATURE OF PHYSICIAN OR SUPPLIER INCLUDING DEGREES OR CREDENTIALS (I certify that the statements on the reverse apply to this bill and are made a part thereof.)

Stephanie Sloan, OD 06/30/03

SIGNED DATE

32. NAME AND ADDRESS OF FACILITY WHERE SERVICES WERE RENDERED (If other than home or office)

Stephanie Sloan, OD
123 Medical Drive
Anytown, MT 59999

33. PHYSICIAN'S, SUPPLIER'S BILLING NAME, ADDRESS, ZIP CODE & PHONE #

Stephanie Sloan, OD
P.O. Box 999
Anytown, MT 59999

PIN# 999999 GRP# (406) 999-9999

(APPROVED BY AMA COUNCIL ON MEDICAL SERVICE 8/88) ***PLEASE PRINT OR TYPE*** FORM HCFA-1500 (12-90), FORM RRB-1500, FORM OWCP-1500

CMS-1500 Agreement

Your signature on the CMS-1500 constitutes your agreement to the terms presented on the back of the form. This form is subject to change by the Centers for Medicare and Medicaid Services (CMS).

BECAUSE THIS FORM IS USED BY VARIOUS GOVERNMENT AND PRIVATE HEALTH PROGRAMS, SEE SEPARATE INSTRUCTIONS ISSUED BY APPLICABLE PROGRAMS.

NOTICE: Any person who knowingly files a statement of claim containing any misrepresentation or any false, incomplete or misleading information may be guilty of a criminal act punishable under law and may be subject to civil penalties.

REFERS TO GOVERNMENT PROGRAMS ONLY

MEDICARE AND CHAMPUS PAYMENTS: A patient's signature requests that payment be made and authorizes release of any information necessary to process the claim and certifies that the information provided in Blocks 1 through 12 is true, accurate and complete. In the case of a Medicare claim, the patient's signature authorizes any entity to release to Medicare medical and nonmedical information, including employment status, and whether the person has employer group health insurance, liability, no-fault, worker's compensation or other insurance which is responsible to pay for the services for which the Medicare claim is made. See 42 CFR 411.24(a). If item 9 is completed, the patient's signature authorizes release of the information to the health plan or agency shown. In Medicare assigned or CHAMPUS participation cases, the physician agrees to accept the charge determination of the Medicare carrier or CHAMPUS fiscal intermediary as the full charge, and the patient is responsible only for the deductible, coinsurance and noncovered services. Coinsurance and the deductible are based upon the charge determination of the Medicare carrier or CHAMPUS fiscal intermediary if this is less than the charge submitted. CHAMPUS is not a health insurance program but makes payment for health benefits provided through certain affiliations with the Uniformed Services. Information on the patient's sponsor should be provided in those items captioned in "Insured"; i.e., items 1a, 4, 6, 7, 9, and 11.

BLACK LUNG AND FECA CLAIMS

The provider agrees to accept the amount paid by the Government as payment in full. See Black Lung and FECA instructions regarding required procedure and diagnosis coding systems.

SIGNATURE OF PHYSICIAN OR SUPPLIER (MEDICARE, CHAMPUS, FECA AND BLACK LUNG)

I certify that the services shown on this form were medically indicated and necessary for the health of the patient and were personally furnished by me or were furnished incident to my professional service by my employee under my immediate personal supervision, except as otherwise expressly permitted by Medicare or CHAMPUS regulations.

For services to be considered as "incident" to a physician's professional service, 1) they must be rendered under the physician's immediate personal supervision by his/her employee, 2) they must be an integral, although incidental part of a covered physician's service, 3) they must be of kinds commonly furnished in physician's offices, and 4) the services of nonphysicians must be included on the physician's bills.

For CHAMPUS claims, I further certify that I (or any employee) who rendered services am not an active duty member of the Uniformed Services or a civilian employee of the United States Government or a contract employee of the United States Government, either civilian or military (refer to 5 USC 5536). For Black-Lung claims, I further certify that the services performed were for a Black Lung-related disorder.

No Part B Medicare benefits may be paid unless this form is received as required by existing law and regulations (42 CFR 424.32).

NOTICE: Any one who misrepresents or falsifies essential information to receive payment from Federal funds requested by this form may upon conviction be subject to fine and imprisonment under applicable Federal laws.

NOTICE TO PATIENT ABOUT THE COLLECTION AND USE OF MEDICARE, CHAMPUS, FECA, AND BLACK LUNG INFORMATION

(PRIVACY ACT STATEMENT)

We are authorized by HCFA, CHAMPUS and OWCP to ask you for information needed in the administration of the Medicare, CHAMPUS, FECA, and Black Lung programs. Authority to collect information is in section 205(a), 1862, 1872 and 1874 of the Social Security Act as amended, 42 CFR 411.24(a) and 424.5(a) (6), and 44 USC 3101;41 CFR 101 et seq and 10 USC 1079 and 1086; 5 USC 8101 et seq; and 30 USC 901 et seq; 38 USC 613; E.O. 9397.

The information we obtain to complete claims under these programs is used to identify you and to determine your eligibility. It is also used to decide if the services and supplies you received are covered by these programs and to insure that proper payment is made.

The information may also be given to other providers of services, carriers, intermediaries, medical review boards, health plans, and other organizations or Federal agencies, for the effective administration of Federal provisions that require other third parties payers to pay primary to Federal program, and as otherwise necessary to administer these programs. For example, it may be necessary to disclose information about the benefits you have used to a hospital or doctor. Additional disclosures are made through routine uses for information contained in systems of records.

FOR MEDICARE CLAIMS: See the notice modifying system No. 09-70-0501, titled, 'Carrier Medicare Claims Record,' published in the Federal Register, Vol. 55 No. 177, page 37549, Wed. Sept. 12, 1990, or as updated and republished.

FOR OWCP CLAIMS: Department of Labor, Privacy Act of 1974, "Republication of Notice of Systems of Records," Federal Register Vol. 55 No. 40, Wed Feb. 28, 1990, See ESA-5, ESA-6, ESA-12, ESA-13, ESA-30, or as updated and republished.

FOR CHAMPUS CLAIMS: PRINCIPLE PURPOSE(S): To evaluate eligibility for medical care provided by civilian sources and to issue payment upon establishment of eligibility and determination that the services/supplies received are authorized by law.

ROUTINE USE(S): Information from claims and related documents may be given to the Dept. of Veterans Affairs, the Dept. of Health and Human Services and/or the Dept. of Transportation consistent with their statutory administrative responsibilities under CHAMPUS/CHAMPVA; to the Dept. of Justice for representation of the Secretary of Defense in civil actions; to the Internal Revenue Service, private collection agencies, and consumer reporting agencies in connection with recoupment claims; and to Congressional Offices in response to inquiries made at the request of the person to whom a record pertains. Appropriate disclosures may be made to other federal, state, local, foreign government agencies, private business entities, and individual providers of care, on matters relating to entitlement, claims adjudication, fraud, program abuse, utilization review, quality assurance, peer review, program integrity, third-party liability, coordination of benefits, and civil and criminal litigation related to the operation of CHAMPUS.

DISCLOSURES: Voluntary; however, failure to provide information will result in delay in payment or may result in denial of claim. With the one exception discussed below, there are no penalties under these programs for refusing to supply information. However, failure to furnish information regarding the medical services rendered or the amount charged would prevent payment of claims under these programs. Failure to furnish any other information, such as name or claim number, would delay payment of the claim. Failure to provide medical information under FECA could be deemed an obstruction.

It is mandatory that you tell us if you know that another party is responsible for paying for your treatment. Section 1128B of the Social Security Act and 31 USC 3801-3812 provide penalties for withholding this information.

You should be aware that P.L. 100-503, the "Computer Matching and Privacy Protection Act of 1988", permits the government to verify information by way of computer matches.

MEDICAID PAYMENTS (PROVIDER CERTIFICATION)

I hereby agree to keep such records as are necessary to disclose fully the extent of services provided to individuals under the State's Title XIX plan and to furnish information regarding any payments claimed for providing such services as the State Agency or Dept. of Health and Humans Services may request.

I further agree to accept, as payment in full, the amount paid by the Medicaid program for those claims submitted for payment under that program, with the exception of authorized deductible, coinsurance, co-payment or similar cost-sharing charge.

SIGNATURE OF PHYSICIAN (OR SUPPLIER): I certify that the services listed above were medically indicated and necessary to the health of this patient and were personally furnished by me or my employee under my personal direction.

NOTICE: This is to certify that the foregoing information is true, accurate and complete. I understand that payment and satisfaction of this claim will be from Federal and State funds, and that any false claims, statements, or documents, or concealment of a material fact, may be prosecuted under applicable Federal or State laws.

Public reporting burden for this collection of information is estimated to average 15 minutes per response, including time for reviewing instructions, searching existing date sources, gathering and maintaining data needed, and completing and reviewing the collection of information. Send comments regarding this burden estimate or any other aspect of this collection of information, including suggestions for reducing the burden, to HCFA, Office of Financial Management, P.O. Box 26684, Baltimore, MD 21207; and to the Office of Management and Budget, Paperwork Reduction Project (OMB-0938-0008), Washington, D.C. 20503.

Avoiding Claim Errors

Claims are often denied or even returned to the provider before they can be processed. To avoid denials and returns, double check each claim to confirm the following items are accurate. For more information on returned and denied claims, see the *Billing Procedures* chapter in this manual.

Common Claim Errors

Claim Error	Prevention
Required field is blank	Check the claim instructions earlier in this chapter for required fields (indicated by * or **). If a required field is blank, the claim may either be returned or denied.
Client ID number missing or invalid	This is a required field (field 10d); verify that the client's Medicaid ID number is listed as it appears on the client's ID card.
Client name missing	This is a required field (field 2); check that it is correct.
Medicaid provider number missing or invalid	The provider number is a 7-digit number assigned to the provider during Medicaid enrollment. Verify the correct **Medicaid** provider number is on the claim.
Referring or PASSPORT provider name and ID number missing	When a provider refers a client to another provider, include the referring provider's name and ID number or PASSPORT number (see *PASSPORT and Prior Authorization* in this manual).
Prior authorization number missing	When prior authorization (PA) is required for a service, the PA number must be listed on the claim in field 23 (see *Prior Authorization* in this manual).
Not enough information regarding other coverage	Fields 1a and 11d are required fields when a client has other coverage (refer to the examples earlier in this chapter).
Authorized signature missing	Each claim must have an authorized signature belonging to the provider, billing clerk, or office personnel. The signature may be typed, stamped, or hand-written.
Signature date missing	Each claim must have a signature date.
Incorrect claim form used	Services covered in this manual require a CMS-1500 claim form (or electronic Professional claim).
Information on claim form not legible	Information on the claim form must be legible. Use dark ink and center the information in the field. Information must not be obscured by lines.
Medicare EOMB not attached	When Medicare is involved in payment on a claim, the Medicare EOMB must be attached to the claim or it will be denied.

Other Programs

This chapter applies to claims completed for CHIP eyeglass services. This chapter does not apply to CHIP optometric services because they are covered by the Blue-CHIP Plan of Blue Cross and Blue Shield of Montana.

MONTANA
Department of Public Health & Human Services

Remittance Advices and Adjustments

The Remittance Advice

The Remittance Advice (RA) is the best tool providers have to determine the status of a claim. RAs accompany payment for services rendered. The RA provides details of all transactions that have occurred during the previous RA cycle. Providers may select a one or two week payment cycle (see *Payment and the RA* in this chapter). Each line of the RA represents all or part of a claim, and explains whether the claim or service has been paid, denied, or suspended (also referred to as pending). If the claim was suspended or denied, the RA also shows the reason.

Electronic RAs are available for only six weeks on MEPS.

Electronic RA

Providers may receive the RA electronically as an ANSI ASC X12N 835 transaction, or through the Internet on the Montana Eligibility and Payment System (MEPS). For more information on X12N 835 transactions, see the Companion Guides available on the ACS EDI Gateway website and the Implementation Guides on the Washington Publishing Company website (see *Key Contacts*).

MEPS is available through the Virtual Human Services Pavilion (see *Key Contacts*). In order to access MEPS, you must complete an *Access Request Form;* see *Payment and the RA* within this chapter). After this form has been processed, you will receive a password. Entry into the system requires a valid provider or group number and password. Each provider or group number requires a unique password, so providers must complete a separate request form for each provider or group.

If a claim was denied, please read the reason and remark code description before taking any action on the claim.

RAs are available from MEPS in PDF and a flat file format. You can read, print, or download PDF files using Adobe Acrobat Reader, which is available on the "SOR Download" page. The file layout for flat files is also available on the SOR download page. Due to space limitations, each RA is only available for six weeks. For more information on MEPS, see *Payment and the RA* later in this chapter.

Paper RA

The paper RA is divided into the following sections: RA notice, paid claims, denied claims, pending claims, credit balance claims, gross adjustments, and reason and remark codes and descriptions. See the following sample paper RA and the *Keys to the Paper RA* table.

The pending claims section of the RA is informational only. Please do not take any action on claims displayed here.

Sections of the Paper RA

Section	Description
RA notice	The RA Notice is on the first page of the remittance advice. This section contains important messages about rate changes, revised billing procedures, and many other items that may affect providers and claims.
Paid claims	This section shows claims paid during the previous cycle. It is the provider's responsibility to verify that claims were paid correctly. If Medicaid overpays a claim and the problem is not corrected, it may result in an audit requiring the provider to return the overpayment plus interest. If a claim was paid at the wrong amount or with incorrect information, the claim must be adjusted (see *Adjustments* later in this chapter).
Denied claims	This section shows claims denied during the previous cycle. If a claim has been denied, refer to the Reason/Remark column (Field 16). The reason and remark code description explains why the claim was denied and is located at the end of the RA. See *The Most Common Billing Errors and How to Avoid Them* in the *Billing Procedures* chapter.
Pending claims	All claims that have not reached final disposition will appear in this area of the paper RA (pended claims are not available on X12N 835 transactions). The RA uses "suspended" and "pending" interchangeably. They both mean that the claim has not reached final disposition. If a claim is pending, refer to the Reason/Remark Code column (Field 16). The reason and remark code description located at the end of the RA will explain why the claim is suspended. This section is informational only. Please do not take any action on claims displayed here. Processing will continue until each claim is paid or denied. Claims shown as pending with reason code 133 require additional review before a decision to pay or deny is made. If a claim is being held while waiting for client eligibility information, it may be suspended for a maximum of 30 days. If Medicaid receives eligibility information within the 30-day period, the claim will continue processing. If no eligibility information is received within 30 days, the claim will be denied. When a claim is denied for lack of eligibility, the provider should verify that the correct Medicaid ID number was billed. If the ID number was incorrect, resubmit the claim with the correct ID number.
Credit balance claims	Credit balance claims are shown here until the credit has been satisfied.
Gross adjustments	Any gross adjustments performed during the previous cycle are shown here.
Reason and remark code description	This section lists the reason and remark codes that appear throughout the RA with a brief description of each.

Sample Remittance Advice

DEPARTMENT OF PUBLIC HEALTH & HUMAN SERVICES
HELENA, MT 59604

MEDICAID REMITTANCE ADVICE

(1)

JOHN R. SMITH MD
2100 NORTH MAIN STREET
WESTERN CITY MT 59988

(2) PROVIDER# 0001234567 (3) REMIT ADVICE #123456 (4) WARRANT # 654321 (5) DATE:02/15/03 PAGE 2 (6)

RECIP ID (7)	NAME (8)	SERVICE DATES FROM	TO (10)	UNIT OF SVC (11)	PROCEDURE REVENUE NDC (12)	TOTAL CHARGES (13)	ALLOWED (14)	CO-PAY (15)	REASON/ REMARK CODES (16)
PAID CLAIMS - MISCELLANEOUS CLAIMS									
123456789	DOE, JOHN EDWARD	013103	013103	1	99212	35.00	28.90	Y	
(9) ICN	00204011250000700								
		LESS MEDICARE PAID*******					21.95		
		LESS COPAY DEDUCTION**					2.00 (17)		
		CLAIM TOTAL*******				35.00	4.95		
DENIED CLAIMS - MISCELLANEOUS CLAIMS									
123456789	DOE, JOHN EDWARD	020303	020303	1	99213	45.00	0.00	N	
ICN	00204011250000800	ADDITIONAL EOB: 082 (16)							
		020403	020403	1	99214	60.00	0.00 (17)	N	
		CLAIM TOTAL*******				105.00			31MA61
PENDING CLAIMS - MISCELLANEOUS CLAIMS									
123456789	DOE, JOHN EDWARD	020503	020503	1	99213	45.00	0.00 (17)	N	133
ICN	00204011250000900	020603	020603	1	99214	60.00	0.00	N	133
		CLAIM TOTAL*******				105.00			

**********THE FOLLOWING IS A DESCRIPTION OF THE REASON/REMARK CODES THAT APPEAR ABOVE**********

31 CLAIM DENIED AS PATIENT CANNOT BE IDENTIFIED AS OUR INSURED.

133 THE DISPOSITION OF THIS CLAIM/SERVICE IS PENDING FURTHER REVIEW.

MA61 DID NOT COMPLETE OR ENTER CORRECTLY THE PATIENT'S SOCIAL SECURITY NUMBER OR HEALTH INSURANCE CLAIM NUMBER.

Key Fields on the Remittance Advice

Field	Description
1. Provider name and address	Provider's business name and address as recorded with the Department
2. Provider number	The 7-digit number assigned to the provider by Medicaid
3. Remittance advice number	The remittance advice number
4. Warrant number	Not used
5. Date	The date the RA was issued
6. Page Number	The page number of the RA
7. Recipient ID	The client's Medicaid ID number
8. Name	The client's name
9. Internal control number (ICN)	Each claim is assigned a unique 17-digit number (ICN). Use this number when you have any questions concerning your claim. The claim number represents the following information: 0 00111 00 123 000123 A B C D E A = Claim medium 0 = Paper claim 2 = Electronic claim 3 = Encounter claim 4 = System generated claim (mass adjustment, nursing home turn-around document, or point-of-sale (POS) pharmacy claim) B = Julian date (e.g. April 20, 2000 was the 111th day of 2000) C = Microfilm number 00 = Electronic claim 11 = Paper claim D = Batch number E = Claim number If the first number is: 0 = Regular claim 1 = Negative side adjustment claim (Medicaid recovers payment) 2 = Positive side adjustment claim (Medicaid reprocesses)
10. Service dates	Date(s) services were provided. If service(s) were performed in a single day, the same date will appear in both columns
11. Unit of service	The units of service rendered under this procedure, NDC, or revenue code.
12. Procedure/revenue/NDC	The procedure code (CPT, HCPCS, or local), National Drug Code (NDC), or revenue code will appear in this column. If a modifier was used, it will also appear in this column.
13. Total charges	The amount a provider billed for this service.
14. Allowed	The Medicaid allowed amount.
15. Copay	A "Y" indicates cost sharing was deducted from the allowed amount, and an "N" indicates cost sharing was not deducted.
16. Reason/Remark Codes	A code which explains why the specific service was denied or pended. Descriptions of these codes are listed at the end of the RA.
17. Deductions, billed amount, and paid amount	Any deductions, such as cost sharing or third party liability are listed first. The amount the provider billed is next, followed by the amount of Medicaid reimbursement.

Credit balances

Credit balances occur when claim adjustments reduce original payments causing the provider to owe money to the Department. These claims are considered in process and continue to appear on the RA until the credit has been satisfied.

Credit balances can be resolved in two ways:

1. By "working off" the credit balance. Remaining credit balances can be deducted from future claims. These claims will continue to appear on consecutive RAs until the credit has been paid.
2. By sending a check payable to DPHHS for the amount owed. This method is required for providers who no longer submit claims to Montana Medicaid. Please attach a note stating that the check is to pay off a credit balance and include your provider number. Send the check to the attention of the *Provider Relations Field Representative* at the Provider Relations address in *Key Contacts*.

The credit balance section is informational only. Do not post from credit balance statements.

Rebilling and Adjustments

Rebillings and adjustments are important steps in correcting any billing problems you may experience. Knowing when to use the rebilling process versus the adjustment process is important.

How long do I have to rebill or adjust a claim?

- Providers may resubmit or adjust any initial claim within the timely filing limits described in the *Billing Procedures* chapter of this manual.
- These time periods do not apply to overpayments that the provider must refund to the Department. After the 12 month time period, a provider may not refund overpayments to the Department by completing a claim adjustment. The provider may refund overpayments by issuing a check or requesting Provider Relations to complete a gross adjustment.

Medicaid does not accept any claim for resubmission or adjustment after 12 months from the date of service (see *Timely Filing Limits* in *Billing Procedures* chapter).

Rebilling Medicaid

Rebilling is when a provider submits a claim (or claim line) to Medicaid that was previously submitted for payment but was either returned or denied. Claims are often returned to the provider before processing because key information such as Medicaid provider number or authorized signature and date are missing or unreadable. For tips on preventing returned or denied claims, see the *Billing Procedures* and *Completing a Claim* chapters.

When to rebill Medicaid

- ***Claim Denied.*** Providers can rebill Medicaid when a claim is denied in full, as long as the claim was denied for reasons that can be corrected. When the entire claim is denied, check the Explanation of Benefits (EOB) code, make the appropriate corrections, and resubmit the corrected claim on a CMS-1500 form (not the adjustment form).

Rebill denied claims only after appropriate corrections have been made.

- ***Line Denied.*** When an individual line is denied on a multiple-line claim, correct any errors and rebill Medicaid. Either submit the denied service on a new CMS-1500 form, or cross out paid lines and resubmit the form. Do not use an adjustment form.
- ***Claim Returned.*** Rebill Medicaid when the claim is returned under separate cover. Occasionally, Medicaid is unable to process the claim and will return it to the provider with a letter stating that additional information is needed to process the claim. Correct the information as directed and resubmit your claim.

How to rebill

- Check any EOB code listed and make your corrections on a copy of the claim, or produce a new claim with the correct information.
- When making corrections on a copy of the claim, remember to cross out or omit all lines that have already been paid. The claim must be neat and legible for processing.
- Enter any insurance (TPL) information on the corrected claim, or attach insurance denial information to the corrected claim, and send it to Claims Processing (see *Key Contacts*).

Adjustments

If a provider believes that a claim has been paid incorrectly, the provider may call Provider Relations (see *Key Contacts*) or submit a claim inquiry for review (see *Billing Procedures, Claim Inquiry*). Once an incorrect payment has been verified, the provider may submit an *Individual Adjustment Request* form (in *Appendix A*) to Provider Relations. If incorrect payment was the result of an ACS keying error, contact Provider Relations.

Adjustments can only be made to paid claims.

When adjustments are made to previously paid claims, the Department recovers the original payment and issues appropriate repayment. The result of the adjustment appears on the provider's RA as two transactions. The original payment will appear as a credit transaction. The replacement claim reflecting the corrections will be listed as a separate transaction and may or may not appear on the same RA as the credit transaction. The replacement transaction will have nearly the same ICN number as the credit transaction, except the 12th digit will be a 2, indicating an adjustment. See *Key Fields on the Remittance Advice* earlier in this chapter. Adjustments are processed in the same time frame as claims.

When to request an adjustment

- Request an adjustment when a claim was overpaid or underpaid.
- Request an adjustment when a claim was paid but the information on the claim was incorrect (such as client ID, provider number, date of service, procedure code, diagnoses, units, etc.).

How to request an adjustment

To request an adjustment, use the *Montana Medicaid Individual Adjustment Request* form in *Appendix A.* The requirements for adjusting a claim are as follows:

- Claims Processing must receive individual claim adjustment requests within 12 months from the date of service (see *Timely Filing Limits* in the *Billing Procedures* chapter). After this time, *gross adjustments* are required (see *Definitions*).
- Use a separate adjustment request form for each ICN.
- If you are correcting more than one error per ICN, use only one adjustment request form, and include each error on the form.
- If more than one line of the claim needs to be adjusted, indicate which lines and items need to be adjusted in the *Remarks* section of the adjustment form.

MONTANA MEDICAID/MHSP/CHIP
INDIVIDUAL ADJUSTMENT REQUEST

INSTRUCTIONS:
This form is for providers to correct a claim which has been paid at an incorrect amount or was paid with incorrect information. Complete all the fields in Section A with information about the paid claim from your statement. Complete ONLY the items in Section B which represent the incorrect information that needs changing. For help with this form, refer to the *Remittance Advices and Adjustments* chapter in your program manual or the *General Information For Providers II* manual, or call (800) 624-3958 (Montana Providers) or (406) 442-1837 (Helena and out-of-state providers).

A. COMPLETE ALL FIELDS USING THE PAYMENT STATEMENT (R.A.) FOR INFORMATION

1. PROVIDER NAME & ADDRESS: Dr. John R. Smith, MD Name 123 Medical Drive Street or P.O. Box Anytown, MT 59999 City State Zip	3. INTERNAL CONTROL NUMBER (ICN): 00204011250000600 4. PROVIDER NUMBER: 1234567 5. CLIENT ID NUMBER: 123456789 6. DATE OF PAYMENT: 02/15/03
2. CLIENT NAME: Jane Doe	7. AMOUNT OF PAYMENT $: 11.49

B. COMPLETE ONLY THE ITEM(S) WHICH NEED TO BE CORRECTED

	DATE OF SERVICE OR LINE NUMBER	INFORMATION STATEMENT	CORRECTED INFORMATION
1. Units of Service	Line 2	2	1
2. Procedure Code/N.D.C./Revenue Code			
3. Dates of Service (D.O.S.)	Line 3	02/01/03	01/23/03
4. Billed Amount			
5. Personal Resource (Nursing Home)			
6. Insurance Credit Amount			
7. Net (Billed - TPL or Medicare Paid)			
8. Other/REMARKS (BE SPECIFIC)			

SIGNATURE: John R. Smith, M.D. DATE: 04/15/03

When the form is complete, attach a copy of the payment statement (RA) and a copy of the corrected claim (unless you bill EMC).

MAIL TO: Provider Relations
ACS
P.O. Box 8000
Helena, MT 59604

Sample Adjustment Request

Completing an Adjustment Request Form

1. Copy the *Montana Medicaid Individual Adjustment Request* form from *Appendix A.* You may also order forms from Provider Relations or download them from the *Provider Information* website (see *Key Contacts*). Complete Section A first with provider and client information and the claim's ICN number (see following table and sample RA).
2. Complete Section B with information about the claim. Remember to fill in only the items that need to be corrected (see following table):
   - Enter the date of service or the line number in the *Date of Service or Line Number* column.
   - Enter the information from the claim that was incorrect in the *Information on Statement* column.
   - Enter the correct information in the column labeled *Corrected Information*.

Completing an Individual Adjustment Request Form

Field	Description
Section A	
1. Provider name and address	Provider's name and address (and mailing address if different).
2. Client name	The client's name is here.
3.* Internal control number (ICN)	There can be only one ICN per adjustment request form. When adjusting a claim that has been previously adjusted, use the ICN of the most recent adjusted claim.
4.* Provider number	The provider's Medicaid ID number.
5.* Client Medicaid number	Client's Medicaid ID number.
6. Date of payment	Date claim was paid is found on remittance advice field #5 (see the sample RA earlier in this chapter).
7. Amount of payment	The amount of payment from the remittance advice field #17 (see the sample RA earlier in this chapter.).
Section B	
1. Units of service	If a payment error was caused by an incorrect number of units, complete this line.
2. Procedure code/ NDC/ Revenue code	If the procedure code, NDC, or revenue code is incorrect, complete this line.
3. Dates of service (D.O.S)	If the date(s) of service is incorrect, complete this line.
4. Billed amount	If the billed amount is incorrect, complete this line.
5. Personal resource (Nursing facility)	If the client's personal resource amount is incorrect, complete this line.
6. Insurance credit amount	If the client's insurance credit amount is incorrect, complete this line.
7. Net (Billed – TPL or Medicare paid)	If the payment error was caused by a missing or incorrect insurance credit, complete this line. Net is billed amount minus the amount third party liability or Medicare paid.
8. Other/Remarks	If none of the above items apply, or if you are unsure what caused the payment error, complete this line.

* Indicates a required field

3. Attach copies of the RA and a corrected claim if necessary.
   - If the original claim was billed electronically, a copy of the RA will suffice.
   - If the RA is electronic, attach a screen print of the RA.
4. Verify the adjustment request has been signed and dated.
5. Send the adjustment request to Claims Processing (see *Key Contacts*).

- If an original payment was an underpayment by Medicaid, the adjustment will result in the provider receiving the additional payment amount allowed.
- If an original payment was an overpayment by Medicaid, the adjustment will result in recovery of the overpaid amount through a credit balance or a check from the provider (see *Credit balances* earlier in this chapter).
- Any questions regarding claims or adjustments can be directed to Provider Relations (see *Key Contacts*).

Mass adjustments

Mass adjustments are done when it is necessary to reprocess multiple claims. They generally occur when:

- Medicaid has a change of policy or fees that is retroactive. In this case federal laws require claims affected by the changes to be mass adjusted.
- A system error that affected claims processing is identified.

Providers are informed of mass adjustments by a Provider Notice or on the first page of the remittance advice (RA Notice section). Mass adjustment claims shown on the RA have an ICN that begins with a "4" (see *Key Fields on the Remittance Advice* earlier in this chapter).

Payment and The RA

Providers may receive their Medicaid payment and remittance advice either weekly or biweekly. Payment can be via check or electronic funds transfer (EFT). Direct deposit is another name for EFT. Providers who wish to receive weekly payment must request both EFT and electronic RAs and specifically request weekly payment. For biweekly payment, providers can choose any combination of paper/electronic payment method and RA.

With EFT, the Department deposits the funds directly to the provider's bank account. If the scheduled deposit day is a holiday, funds will be available on the next business day. This process does not affect the delivery of the remittance advice that providers currently receive with payments. RAs will continue to be mailed to providers unless they specifically request an electronic RA.

To participate in EFT, providers must complete a *Direct Deposit Sign-Up Form* (Standard Form 1199A). One form must be completed for each provider number. See the following table, *Required Forms for EFT and/or Electronic RA.*

Weekly payments are available only to providers who receive both EFT **and** electronic RAs.

Once electronic transfer testing shows payment to the provider's account, all Medicaid payments will be made through EFT. See *Direct Deposit Arrangements* under *Key Contacts* for questions or changes regarding EFT.

Required Forms For EFT and/or Electronic RA

All three forms are required for a provider to receive weekly payment

Form	Purpose	Where to Get	Where to Send
Electronic Remittance Advice and Payment Cycle Enrollment Form	Allows provider to receive electronic remittance advices on MEPS (must also include MEPS Access Request form)	• Provider Information website • Provider Relations (see *Key Contacts*)	Provider Relations (see *Key Contacts*)
Direct Deposit Sign-up Form Standard Form 1199A	Allows the Department to automatically deposit Medicaid payment into provider's bank account	• Provider Information website (see *Key Contacts*) • Provider's bank	Provider Relations (see *Key Contacts*)
MEPS Access Request Form	Allows provider to receive a password to access their RA on MEPS	• Provider Information website • Virtual Human Services Pavilion • Direct Deposit Arrangements (see *Key Contacts)*	DPHHS address on the form

Other Programs

The information in this chapter applies to the Children's Health Insurance Plan (CHIP) eyeglasses only. Optometric services are covered under the BlueCHIP plan of BlueCross BlueShield of Montana.

How Payment Is Calculated

Overview

Though providers do not need the information in this chapter in order to submit claims to the Department, the information allows providers to understand how payment is calculated and to predict approximate payment for particular claims.

The RBRVS Fee Schedule

Most services provided by optometrists, opticians, and ophthalmologists are paid for using the Department's RBRVS fee schedule. RBRVS stands for Resource-Based Relative Value Scale. The fee schedule includes about 7,700 CPT-4 codes, about 1,600 HCPCS Level 2 codes.

RBRVS was developed for the Medicare program, which first implemented it in 1992. Medicare does a major update annually, with smaller updates performed quarterly. Montana Medicaid implemented its RBRVS-based fee schedule in August 1997. It is based largely on the Medicare model, with a few differences that are described below. By adapting the Medicare model to the needs of the Montana Medicaid program, the Department was able to take advantage of the millions of dollars of research performed by the federal government and national associations of physicians and other health care professionals. RBRVS-based payment methods are widely used across the U.S. by Medicaid programs, BlueCross BlueShield plans, workers' compensation plans and commercial insurers.

Many Medicaid payment methods are based on Medicare, but there are differenses, in these cases, the Medicaid method prevails.

The following paragraphs elaborate on aspects of the RBRVS fee schedule used by the Department. All numerical examples are from July 2002 and may not apply at other times.

Fee calculation

Each fee is the product of a relative value times a conversion factor. For example, the fee for a Level 2 office visit for an established client (99212) is:

0.906 relative value units x conversion factor of $31.90 = $28.90

Basis of relative values

For almost all services, Medicaid uses the same relative values as Medicare does in Montana. (Nationally, Medicare adjusts the relative values for differences in practice costs between

When Medicaid payment differs from the fee schedule, consider the following:

- The Department pays the lower of the established Medicaid fee or the provider's charge
- Modifiers (see *Other modifiers* in this chapter)
- Provider type (see *Professional differentials* in this chapter)
- Place of service (see *Site of service differential* in this chapter)
- Date of service (fees for services may change over time)
- Also check for cost sharing and Medicare or TPL payments which will be shown on the remittance advice.

localities, but Montana is considered a single locality.) For fewer than 1% of codes, relative values are not available from Medicare. For these codes, the Department has set the relative values.

Composition of relative values

For each code, the relative value is the sum of a relative value for the work effort (including time, stress, and difficulty), the associated practice expense and the associated malpractice expense. For a Level 2 office visit (99212), for example, the composition is as follows:

0.428 work RVUs + 0.464 practice expense RVUS + 0.015 malpractice expense RVUs = 0.906 total RVUs

Site of service differential

The Medicare program has calculated two sets of relative values for each code – one that reflects the practitioner's practice cost of performing the service in an office and one that reflects the practitioner's practice cost of performing the service in a hospital or ambulatory surgical center (ASC). When services are provided within a hospital or ASC (i.e., places of service 21, 22, 23, and 24), Medicaid typically pays a lower fee than if the service is provided in the office or another setting. The reason is that Medicaid typically also pays the hospital or ASC for the service. For example, in July 2002 Medicaid would pay a provider for a Level 2 office visit (99212) as follows:

In office: 0.906 RVUs x conversion factor of $31.90 = $28.90

In hospital or ASC: 0.591 RVUs x $31.90 = $18.85

Conversion factor

The Department sets the conversion factor for the state fiscal year (July through June). The conversion factor is typically reviewed (and often changed) in July of each year. In July 2002 it was updated to $31.90, compared with the Medicare conversion factor of $36.20.

Transition adjustor

Because the move to an RBRVS-based fee schedule in August 1997 resulted in large changes in fees for some services, the Montana legislature directed the Department to pay transitional fees for about 2,250 of the 9,300 services covered by the fee schedule. For about 900 services, the transitional fee is lower than it otherwise would be; for 1,350 services, it is higher than it otherwise would be. The transitional fees are put in place by a transition adjustor. Here are examples:

Level 3 office visit, established patient (99213)

1.263 RVUs x transition adjustor of 0.82 x conversion factor of $31.90 = $33.04

Explore/irrigate tear ducts (68840)

2.643 RVUs x transition adjustor of 1.83 x conversion factor of $31.90 = $154.29

Global periods

For many surgical services, the fee covers both the service and all related care within a specified "global" period. For almost all such codes, the global periods used by Medicaid are identical to those used by Medicare, but in cases of differences the Medicaid policy applies. See the *Billing Procedures* chapter in this manual for more information on global periods.

Providers must take extra care in billing codes that have global periods or are divided into technical and professional components.

Professional and technical components

Some services are divided into the technical component (performing the test) and the professional component (interpreting the test). A practitioner who only performs the test would bill the service with modifier TC; a practitioner who only interprets the test would bill with modifier 26; and a practitioner who performs both components would bill the code without a modifier. (Performance of both components is called the global service.) The fee schedule has separate fees for each component and for the global service. Consider an eye muscle evaluation:

92265-TC: 0.759 RVUs x conversion factor of $31.90 = $24.21
92265-26: 1.117 RVUs x conversion factor of $31.90 = $35.63
92265: 1.876 RVUs x conversion factor of $31.90 = $59.84

Other modifiers

Under the RBRVS fee schedule, certain other modifiers also affect payment. As of July 2002, these are shown in the following table.

How Modifiers Change Pricing

- Modifiers may not be applicable for all services. For services paid via the RBRVS fee schedule, the fee schedule shows the list of services for which modifiers 26, TC, 50, 51, 62, 66 and 80 apply.
- If a modifier does not appear in this list, then it does not affect pricing.
- The list shows summary modifier descriptions. See the CPT-4 and HCPCS Level II coding books for the full text.

Modifier	Definition	How it affects payment
21	Prolonged evaluation and management	The service is paid at 110% of fee.
22	Unusual procedural service	Pay by report.
26	Professional component	For services paid via the RBRVS fee schedule, see the specific service. For other services, payment equals 40% of the fee.
47	Anesthesia by surgeon	Pay by report
50	Bilateral procedure	The procedure is paid at 150% of the fee.
51	Multiple procedures	Each procedure is paid at 50% of the fee.
52	Reduced service	The service is paid at 50% of the fee.
53	Discontinued procedure	The service is paid at 50% of the fee.
54	Surgical care only	The service is paid at 75% of the fee.
55	Postoperative management only	The service is paid at 25% of the fee.
56	Preoperative management only	The service is paid at 25% of the fee.
62	Two surgeons	Each surgeon is paid at 62.5% of the fee.
66	Surgical team	Each surgeon is paid by report.
80	Assistant surgeon	The service is paid at 16% of the fee.
81	Minimum assistant surgeon	The service is paid at 16% of the fee.
82	Assistant surgeon; qualified resident surgeon not available	The service is paid at 16% of the fee.
90	Reference laboratory	Modifier not allowed
AD	Medical supervision of more than four concurrent anesthesia procedures	Each service is paid at 52.5% of the fee.
AS	Physician assistant, nurse practitioner or clinical nurse specialist as assistant at surgery	The service is paid at 16% of the fee.
QK	Medical supervision of 2-4 concurrent anesthesia procedures	Each service is paid at 52.5% of the fee.
QZ	Certified registered nurse anesthetist service without medical direction	The modifier does not reduce the fee, but a professional differential of 90% is applied due to provider type. See *Professional differentials* in this chapter.
SA	Nurse practitioner	Payment equals 90% of the fee for some services but 100% for others. See *Professional differentials* in this chapter.
SB	Nurse midwife	Payment equals 90% of the fee for some services but 100% for others. See *Professional differentials* in this chapter.
TC	Technical component	For services paid via the RBRVS fee schedule, see the specific service. For other services, payment equals 60% of the fee.

Professional differentials

For some services within the scope of RBRVS payment methods, mid-level practitioners are paid differently. Optometrists, ophthalmologists, and opticians are always paid at 100% of the fee schedule, however.

Charge cap

For the services covered in this manual, Medicaid pays the lower of the established Medicaid fee or the provider's charge.

Payment by report

About 4% of services covered by the RBRVS fee schedule do not have fees set for them; these services are typically rare or vaguely specified in the coding guidelines. For these services, payment is set at a percentage of the provider's charge. As of July 2002 the percentage was 51%; the Department typically reviews this percentage each July.

Bundled codes

A few services are covered by the Department but have a fee of zero, meaning that payment for the service is considered bundled into the payment for services that are usually provided with it. Examples are temporary tear duct plug (A4262), permanent tear duct plug (A4261), and special spectacles fitting (92352). Because these services are covered by Medicaid, providers may not bill clients for them on a private pay basis.

Status codes

The RBRVS fee schedule includes status codes that show how each service is paid. The list of status codes is based on that used by Medicare, as shown in the following table.

Table A
Medicare and Medicaid RBRVS Status Values

Medicare Status		Medicaid Status	
A	Active code paid using RVUs	A	Active code paid using RVUs set by Medicare
B	Bundled code	B	Bundled code
C	Carrier determines coverage and payment	C	Pay by report
D	Deleted code	D	Discontinued code
E	Excluded from fee schedule by regulation		[Medicaid reviews each code and usually assigns A, K or X status]
F	Deleted/discontinued code; no grace period	D	Discontinued code
G	Use another code; grace period allowed	G	Use another code; grace period set code-by-code
H	Modifier deleted		[Assigned to D status]
I	Use another code; no grace period		[Assigned to G status]
		J	Anesthesia code
		K	Active code paid using RVUs set by Medicaid
		L	Not paid via RBRVS. See lab fee schedule.
		M	Not paid via RBRVS. See non-RBRVS fee schedule.
N	Excluded from fee schedule by policy		[Medicaid reviews each code and usually assigns A, K or X status]
P	Bundled or excluded		[Medicaid reviews each code and usually assigns B or X status]
R	Restricted coverage		[Medicaid reviews each code and usually assigns A or K status]
T	Injections		[Medicaid reviews each code and usually assigns A status]
X	Excluded from fee schedule by statute	X	Not covered

Notes:
- Medicare publishes RVUs for codes that have Medicare status values of R and sometimes publishes RVUs for codes with status values of E, N or X.
- Medicare uses the label "injections" for status T but now uses the code for other situations (e.g., pulse oximetry) where Medicare pays for the service only if no other service is performed on the same day.

Payment For Eyeglasses

Payment for eyeglasses is through a single volume purchase contract issued by the Department through the competitive Request for Proposal (RFP) process.

How Cost Sharing Is Calculated on Medicaid Claims

Cost sharing fees are a set dollar amount per visit, and they are based on the average Medicaid allowed amount for the provider type and rounded to the nearest dollar. There is no cost sharing cap (see the *Billing Procedures* chapter, *Client Cost*

Sharing). The client's cost sharing amount is shown on the remittance advice and deducted from the Medicaid allowed amount (see the *Remittance Advices and Adjustments* chapter in this manual). For example, an optometrist performs an eye exam for an established client (92012). The Medicaid allowed amount in July 2002 for this procedure is $37.56. The client would owe the optometrist $2.00 for cost sharing, and Medicaid would pay the provider the remaining $35.56.

How Payment Is Calculated on TPL Claims

When a client has coverage from both Medicaid and another insurance company, the other insurance company is often referred to as third party liability or TPL. In these cases, the other insurance is the primary payer (as described in the C*oordination of Benefits* chapter of this manual), and Medicaid makes a payment as the secondary payer. For example, an optometrist provides a Level 2 office visit (99212) to a client who also has insurance through her job. The client's other insurance is billed first and pays $24.25. The Medicaid allowed amount for this service is $28.90. The amount the other insurance paid ($24.25) is subtracted from the Medicaid allowed amount ($28.90), leaving a balance of $4.65. Medicaid will pay $4.65 on the claim.

Medicaid clients who also have Medicare or TPL are exempt from cost sharing only when the service is allowed by Medicare or paid by the other insurance, and Medicaid is the secondary payer.

How Payment is Calculated on Medicare Crossover Claims

When a client has coverage from both Medicaid and Medicare, Medicare is the primary payer as described in the *Coordination of Benefits* chapter of this manual. Medicaid then makes a payment as the secondary payer. For the provider types covered in this manual, Medicaid's payment is calculated so that the total payment to the provider is either the Medicaid allowed amount less the Medicare paid amount or the sum of the Medicare coinsurance and deductible, whichever is lower. This method is sometimes called "lower of" pricing. The following scenarios are examples of how a Medicare crossover claim is paid. Medicaid incurment is not considered in the following examples. These are only examples and may not reflect current rates.

Scenario 1: Dually eligible client, Medicare paid amount is lower than Medicaid allowed amount, client has already met Medicare deductible.

An optometrist provides a Level 2 visit in her office to a client who is eligible for both Medicare and Medicaid. The client has already met Medicare's requirement for a $100 deductible per year. The Medicare allowed amount for this service (99212) is $32.81. As usual, the Medicare program pays the provider 80% of this amount, or $26.25. The client would be personally responsible for the balance (or coinsurance) of $6.56, except that he has Medicaid as secondary coverage.

Medicaid's allowed amount for this service is $28.90. Because Medicare already paid $26.25, that would leave a difference of $2.65. Medicaid then compares the coinsurance amount ($6.56) to the Medicaid balance ($2.65) and selects the lower of the two amounts. Medicaid would pay the provider $2.65 for this claim

Scenario 1

$ 32.81 Medicare allow.
x 80% Medicare rate
$ 26.25 Medicare paid

$ 32.81 Medicare allow.
- 26.25 Medicare paid
$ 6.56 Medicare coinsurance

$ 28.90 Medicaid allow.
- 26.25 Medicare paid
$ 2.65

$2.65 < $6.56
$ 2.65 Medicaid pays

Providers cannot bill Medicaid clients for the difference between charges and the amount Medicaid paid.

Scenario 2: Dually eligible client, Medicare paid amount is lower than Medicaid allowed amount, client has not met Medicare deductible.

This scenario is the same as Scenario 1, except that the client has not yet met his $100 Medicare deductible. The Medicare allowed amount is $32.81, but because that amount is applied to the client's deductible, Medicare pays zero. The Medicaid allowed amount is $28.90. Medicaid will select the lower of the two amounts and pays the provider $28.90 for this claim.

Scenario 2

$ 32.81 Medicare allowed
- 32.81 Applied to deductible
$ 0.00 Medicare paid

$ 28.90 Medicaid allowed
- 0.00 Medicare paid
$ 28.90

$28.90 < $32.81

$28.90 Medicaid pays

Scenario 3: Dually eligible client, Medicare paid amount is higher than Medicaid allowed amount, client has met Medicare deductible.

Scenario 3

$ 71.86 Medicare allow.
x 80% Medicare rate
$ 57.49 Medicare paid

$ 71.86 Medicare allow.
- 57.49 Medicare paid
$14.37 Medicare coinsurance

$ 50.66 Medicaid allow.
- 57.49 Medicare paid
$ -6.83 Negative value = 0

$0 < $14.37
$0 Medicaid pays

An optometrist provided a Level 4 office visit (99214) to a client who is eligible for Medicare and Medicaid. The Medicare allowed amount is $71.86, which Medicare pays at 80% for $57.49. This leaves the client with a $14.37 Medicare coinsurance.

The Medicaid allowed amount is $50.66. Because Medicare paid $57.49, this would leave a difference of $-6.83. Medicaid considers this negative value equal to $0. Medicaid then compares the coinsurance balance ($14.37) to the Medicaid balance ($0) and pays the lower of the two amounts. Medicaid would pay the provider $0.00 for this claim.

Total payment to the provider from all sources may not exceed the Medicaid allowed amount.

Scenario 4: Dually eligible client, Medicare paid amount is lower than Medicaid allowed amount, client has not met Medicare deductible.

An optometrist provides a neurobehavorial status exam for a client who is eligible for both Medicare and Medicaid. The client has not yet met his $100 Medicare deductible. The Medicare allowed amount for this service (96115) is $56.90. Since the client owes $50.00 for the deductible, Medicare pays 80% of the remaining $6.90 ($5.52), leaving the client with a Medicare coinsurance of $1.38

Medicaid considers the $50 that was applied to the client's Medicare deductible and adds it to the $1.38 coinsurance for a total of $51.38. Medicaid then subtracts the amount Medicare paid ($5.52) from the Medicaid allowed amount ($91.77) for a total of $86.25. Medicaid compares the $51.38 to the $86.25, and selects the lower of the two amounts. Medicaid pays the provider $51.38 for this service.

Scenario 4

$ 56.90 Medicare allow.
- 50.00 Medicare deductible
$ 6.90 Medicare balance

$ 6.90 Medicare balance
x 80% Medicare rate
$5.52 Medicare paid

$ 6.90 Medicare balance
- 5.52 Medicare paid
$ 1.38 Medicare coinsurance

$ 50.00 Medicare deductible
+ 1.38 Medicare coinsurance
$ 51.38

$ 91.77 Medicaid allow.
- 5.52 Medicare paid
$ 86.25

$51.38 < $86.25

$51.38 Medicaid pays

Other Department Programs

The payment method described in this chapter applies to eyeglass services for Children's Health Insurance Plan (CHIP). This chapter does not apply to CHIP optometric services, which are covered under the BlueCHIP plan of BlueCross BlueShield of Montana. For more information on CHIP, visit the CHIP website (see *Key Contacts*).

Appendix A: Forms

- ***Eyeglass Breakage and Loss Form***
- ***Montana Medicaid Rx Form***
- ***Montana CHIP Rx Form***
- ***Montana Medicaid Claim Inquiry Form***
- ***Montana Individual Adjustment Request Form***
- ***Paperwork Attachment Cover Sheet***

Eyeglass Breakage and Loss Form

A. TO BE COMPLETED BY THE PATIENT

Please check one of the following reasons why you are requesting replacement of your eyeglasses.

- ☐ Eyeglasses have been lost or stolen (children only).
- ☐ Frame is broken.
- ☐ One lens is unusable due to scratches or breakage.
- ☐ Both lenses are unusable due to scratches or breakage.
- ☐ Other. Please explain_____

_____

_____ _____

Date Patient Signature (parent for a minor)

##########

B. TO BE COMPLETED BY PROVIDER

☐ Patient brought in broken: frame / lens / lenses.
(Circle Applicable)

_____ _____

Date Provider Signature

MONTANA MEDICAID Rx FORM

PATIENT INFORMATION AND Rx

Patient Name ☐ *Mail to Patient*	Birth Date	Exam Date	Invoice Number
	/ /		
Address Street	PIC Number	ICD-9DX Code	Order Date
City State Zip	Medicaid ID No.	Date Received	Date Shipped

	Sphere	Cylinder	Axis	Prism/Base	Decenter	Distant PD	Near PD
R							
L							

	Add	Near Inset	Total Inset	Seg. Height	OC Height	Center Thickness	Edge Thickness	
R								☐
L								

LENS INFORMATION

Material	Lens Style	Seg Style	Base Curve	
☐ *Plastic*	☐ *SV:*		R	
☐ *Glass*	☐ *Bifocal:*		L	
☐ *High Index*	☐ *Trifocal:*		Lens Coating/Lens Tint	
☐ *Polycarbonate*	☐ *Aphakic:*			
☐ *Other*				

SCRATCH COAT: ☐

FRAME INFORMATION

☐ SUPPLY ☐ LENSES ONLY ☐ EPSDT ☐ 2ND PR S.V. ☐ Rx CHANGE

☐ ZYL ☐ METAL ☐ GROOVE ☐ HALF EYE

Frame Name	Color	Eye Size	Bridge	Temple
			☐ AP ☐ FF	☐ SK ☐ CC

Manufacturer	Frame or Pattern #	Frame Measurements A:	B:	ED:	Shape Code	Circumference

NOTE: A copy of the recipient's medicaid card must be attached to the Rx order.

Reimbursement By	Provider	State
Lenses		
Frame		
Photo-Chromic		
Tint		
Ultra Violet		
Scratch Coat		

TRAY #	PROVIDER NO.	TOTAL

1 Copy - Provider 1 Copy - Lab File 1 Copy - Return with Eyeware

MONTANA CHIP Rx FORM

PATIENT INFORMATION AND Rx

Patient Name ☐ *Mail to Patient*	Birth Date	Exam Date	Invoice Number
	/ /		
Address Street	PIC Number	ICD-9DX Code	Order Date
City State Zip	CHIP ID No.	Date Received	Date Shipped

	Sphere	Cylinder	Axis	Prism/Base	Decenter	Distant PD	Near PD
R							
L							

	Add	Near Inset	Total Inset	Seg. Height	OC Height	Center Thickness	Edge Thickness	
R								☐
L								

LENS INFORMATION

Material	Lens Style	Seg Style	Base Curve	
☐ *Plastic*	☐ *SV:*		R	
☐ *Glass*	☐ *Bifocal:*		L	
☐ *High Index*	☐ *Trifocal:*		Lens Coating/Lens Tint	
☐ *Polycarbonate*	☐ *Aphakic:*			
☐ *Other*				

SCRATCH COAT: ☐

FRAME INFORMATION

☐ SUPPLY ☐ LENSES ONLY ☐ 2ND PR S.V. ☐ Rx CHANGE

☐ ZYL ☐ METAL ☐ GROOVE ☐ HALF EYE

Frame Name	Color	Eye Size	Bridge	Temple
			☐ AP ☐ FF	☐ SK ☐ CC

Manufacturer	Frame or Pattern #	Frame Measurements			Shape Code	Circumference
		A:	B:	ED:		

NOTE: A copy of the recipient's CHIP ID card must be attached to the Rx order.

Reimbursement By	Provider	State
Lenses		
Frame		
Photo-Chromic		
Tint		
Ultra Violet		
Scratch Coat		

TRAY #	PROVIDER NO.	TOTAL	

Montana Medicaid Claim Inquiry Form

Provider Name _____
Contact Person _____
Address _____
Date _____
Phone Number _____
Fax Number _____

For status on a claim, please complete the information on this form and mail to the address below or fax to the number shown. You may attach a copy of the claim, but it is not required.

Provider number _____ Client number _____ Date of service _____ Total billed amount _____ Date submitted for processing _____	ACS Response: _____
Provider number _____ Client number _____ Date of service _____ Total billed amount _____ Date submitted for processing _____	ACS Response: _____
Provider number _____ Client number _____ Date of service _____ Total billed amount _____ Date submitted for processing _____	ACS Response: _____

Mail to: Provider Relations
P.O. Box 8000
Helena, MT 59604

Fax to: (406) 442-4402

MONTANA MEDICAID/MHSP/CHIP
INDIVIDUAL ADJUSTMENT REQUEST

INSTRUCTIONS:

This form is for providers to correct a claim which has been paid at an incorrect amount or was paid with incorrect information. Complete all the fields in Section A with information about the paid claim from your statement. Complete ONLY the items in Section B which represent the incorrect information that needs changing. For help with this form, refer to the *Remittance Advices and Adjustments* chapter in your program manual or the *General Information For Providers II* manual, or call (800) 624-3958 (Montana Providers) or (406) 442-1837 (Helena and out-of-state providers).

A. COMPLETE ALL FIELDS USING THE PAYMENT STATEMENT (R.A.) FOR INFORMATION

1. PROVIDER NAME & ADDRESS

_____
Name

_____
Street or P.O. Box

_____
City State Zip

2. CLIENT NAME

_____

3. INTERNAL CONTROL NUMBER (ICN)

_____

4. PROVIDER NUMBER

_____

5. CLIENT ID NUMBER

_____

6. DATE OF PAYMENT _____

7. AMOUNT OF PAYMENT $ _____

B. COMPLETE ONLY THE ITEM(S) WHICH NEED TO BE CORRECTED

	DATE OF SERVICE OR LINE NUMBER	INFORMATION STATEMENT	CORRECTED INFORMATION
1. Units of Service			
2 Procedure Code/N.D.C./Revenue Code			
3. Dates of Service (D.O.S.)			
4. Billed Amount			
5. Personal Resource (Nursing Home)			
6. Insurance Credit Amount			
7. Net (Billed - TPL or Medicare Paid)			
8. Other/REMARKS (BE SPECIFIC)			

SIGNATURE: _____ **DATE:** _____

When the form is complete, attach a copy of the payment statement (RA) and a copy of the corrected claim (unless you bill EMC).

MAIL TO: ACS
P.O. Box 8000
Helena, MT 59604

MONTANA
Department of Public Health & Human Services

Paperwork Attachment Cover Sheet

Paperwork Attachment Control Number: _____

Date of service: _____

Medicaid provider number: _____

Medicaid client ID number: _____

Type of attachment: _____

Instructions:

This form is used as a cover sheet for attachments to electronic claims sent to Montana Medicaid. The *Paperwork Attachment Control Number* must be the same number as the *Attachment Control Number* on the corresponding electronic claim. This number should consist of the provider's Medicaid ID number, the client's Medicaid ID number and the date of service (mmddyyyy), each separated by a dash (9999999-999999999-99999999). This form may be copied or downloaded from our website www.mtmedicaid.org. If you have questions about which paper attachments are necessary for a claim to process, please call Provider Relations at (406) 442-1837 or (800) 624-3958.

Appendix B: Place of Service Codes

Place of Service Codes		
Codes	**Names**	**Descriptions**
01	Pharmacy**	A facility or location where drugs and other medically related items and services are sold, dispensed, or otherwise provided directly to patients.
02	Unassigned	N/A
03	School	A facility whose primary purpose is education.
04	Homeless shelter	A facility or location whose primary purpose is to provide temporary housing to homeless individuals (e.g., emergency shelters, individual or family shelters).
05	Indian Health Service free-standing facility	A facility or location, owned and operated by the Indian Health Service, which provides diagnostic, therapeutic (surgical and non-surgical), and rehabilitation services to American Indians and Alaska Natives who do not require hospitalization.
06	Indian Health Service provider-based facility	A facility or location, owned and operated by the Indian Health Service, which provides diagnostic, therapeutic (surgical and non-surgical), and rehabilitation services rendered by, or under the supervision of, physicians to American Indians and Alaska Natives admitted as inpatients or outpatients.
07	Tribal 638 free-standing facility	A facility or location owned and operated by a federally recognized American Indian or Alaska Native tribe or tribal organization under a 638 agreement, which provides diagnostic, therapeutic (surgical and non-surgical), and rehabilitation services to tribal members who do not require hospitalization.
08	Tribal 638 provider-based facility	A facility or location owned and operated by a federally recognized American Indian or Alaska Native tribe or tribal organization under a 638 agreement, which provides diagnostic, therapeutic (surgical and non-surgical), and rehabilitation services to tribal members admitted as inpatients or outpatients.
09 - 10	Unassigned	N/A
11	Office	Location, other than a hospital, skilled nursing facility (SNF), military treatment facility, community health center, state or local public health clinic, or intermediate care facility (ICF), where the health professional routinely provides health examinations, diagnosis, and treatment of illness or injury on an ambulatory basis.
12	Home	Location, other than a hospital or other facility, where the patient receives care in a private residence.
13	Assisted living facility	Congregate residential facility with self-contained living units providing assessment of each resident's needs and on-site support 24 hours a day, 7 days a week, with the capacity to deliver or arrange for services including some health care and other services.
14	Group home	A residence, with shared living areas, where clients receive supervision and other services such as social and/or behavioral services, custodial service, and minimal services (e.g., medication administration).
15	Mobile unit	A facility/unit that moves from place-to-place equipped to provide preventive, screening, diagnostic, and/or treatment services.
16 - 19	Unassigned	N/A

Place of Service Codes (continued)

Codes	Names	Descriptions
20	Urgent care facility	Location, distinct from a hospital emergency room, an office, or a clinic, whose purpose is to diagnose and treat illness or injury for unscheduled, ambulatory patients seeking immediate medical attention.
21	Inpatient hospital	A facility, other than psychiatric, which primarily provides diagnostic, therapeutic (both surgical and nonsurgical), and rehabilitation services by, or under, the supervision of physicians to patients admitted for a variety of medical conditions.
22	Outpatient hospital	A portion of a hospital which provides diagnostic, therapeutic (both surgical and nonsurgical), and rehabilitation services to sick or injured persons who do not require hospitalization or institutionalization.
23	Emergency room - hospital	A portion of a hospital where emergency diagnosis and treatment of illness or injury is provided.
24	Ambulatory surgical center	A freestanding facility, other than a physician's office, where surgical and diagnostic services are provided on an ambulatory basis.
25	Birthing center	A facility, other than a hospital's maternity facilities or a physician's office, which provides a setting for labor, delivery, and immediate post-partum care as well as immediate care of newborn infants.
26	Military treatment facility	A medical facility operated by one or more of the uniformed services. Military treatment facility (MTF) also refers to certain former U.S. public health service (USPHS) facilities now designated as uniformed service treatment facilities (USTF).
27 - 30	Unassigned	N/A
31	Skilled nursing facility	A facility which primarily provides inpatient skilled nursing care and related services to patients who require medical, nursing, or rehabilitative services but does not provide the level of care or treatment available in a hospital.
32	Nursing facility	A facility which primarily provides to residents skilled nursing care and related services for the rehabilitation of injured, disabled, or sick person, or, on a regular basis, health-related care services above the level of custodial care to other than mentally retarded individuals.
33	Custodial care facility	A facility which provides room, board and other personal assistance services, generally on a long-term basis, and which does not include a medical component.
34	Hospice	A facility, other than a patient's home, in which palliative and supportive care for terminally ill patients and their families are provided.
35 - 40	Unassigned	N/A
41	Ambulance - land	A land vehicle specifically designed, equipped and staffed for lifesaving and transporting the sick or injured.
42	Ambulance - air or water	An air or water vehicle specifically designed, equipped and staffed for lifesaving and transporting the sick or injured.
43 - 48	Unassigned	N/A
49	Independent clinic	A location, not part of a hospital and not described by any other place of service code, that is organized and operated to provide preventive, diagnostic, therapeutic, rehabilitative, or palliative services to outpatients only.
50	Federally qualified health center	A facility located in a medically underserved area that provides Medicare beneficiaries preventive primary medical care under the general direction of a physician.
51	Inpatient psychiatric facility	A facility that provides inpatient psychiatric services for the diagnosis and treatment of mental illness on a 24-hour basis, by or under the supervision of a physician.

Place of Service Codes (continued)

Codes	Names	Descriptions
52	Psychiatric facility -partial hospitalization	A facility for the diagnosis and treatment of mental illness that provides a planned therapeutic program for patients who do not require full time hospitalization, but who need broader programs than are possible from outpatient visits to a hospital-based or hospital-affiliated facility.
53	Community mental health center	A facility that provides the following services: outpatient services, including specialized outpatient services for children, the elderly, individuals who are chronically ill, and residents of the CMHC's mental health services area who have been discharged from inpatient treatment at a mental health facility; 24 hour a day emergency care services; day treatment, other partial hospitalization services, or psychosocial rehabilitation services: screening for patients being considered for admission to state mental health facilities to determine the appropriateness of such admission; and consultation and education services.
54	Intermediate care facility/ mentally retarded	A facility which primarily provides health-related care and services above the level of custodial care to mentally retarded individuals but does not provide the level of care or treatment available in a hospital or SNF.
55	Residential substance abuse treatment facility	A facility which provides treatment for substance (alcohol and drug) abuse to live-in residents who do not require acute medical care. Services include individual and group therapy and counseling, family counseling, laboratory tests, drugs and supplies, psychological testing, and room and board.
56	Psychiatric residential treatment center	A facility or distinct part of a facility for psychiatric care which provides a total 24-hour therapeutically planned and professionally staffed group living and learning environment.
57	Non-residential substance abuse treatment facility	A location which provides treatment for substance (alcohol and drug) abuse on an ambulatory basis. Services include individual and group therapy and counseling, family counseling, laboratory tests, drugs and supplies, and psychological testing.
58 - 59	Unassigned	N/A
60	Mass immunization center	A location where providers administer pneumococcal pneumonia and influenza virus vaccinations and submit these services as electronic media claims, paper claims, or using the roster billing method. This generally takes place in a mass immunization setting, such as, a public health center, pharmacy, or mall but may include a physician office setting.
61	Comprehensive inpatient rehabilitation facility	A facility that provides comprehensive rehabilitation services under the supervision of a physician to inpatients with physical disabilities. Services include physical therapy , occupational therapy, speech pathology, social or psychological services, and orthotics and prosthetics services.
62	Comprehensive outpatient rehabilitation facility	A facility that provides comprehensive rehabilitation services under the supervision of a physician to outpatients with physical disabilities. Services include physical therapy, occupational therapy, and speech pathology services.
63 - 64	Unassigned	N/A
65	End-stage renal disease treatment facility	A facility other than a hospital, which provides dialysis treatment, maintenance, and/or training to patients or caregivers on an ambulatory or home-care basis.
66 - 70	Unassigned	N/A
71	Public health clinic	A facility maintained by either state or local health departments that provides ambulatory primary medical care under the general direction of a physician.

Place of Service Codes (continued)

Codes	Names	Descriptions
72	Rural health clinic	A certified facility which is located in a rural medically underserved area that provides ambulatory primary medical care under the general direction of a physician.
73 - 80	Unassigned	N/A
81	Independent laboratory	A laboratory certified to perform diagnostic and/or clinical tests independent of an institution or a physician's office.
82 - 98	Unassigned	N/A
99	Other place of service	Other place of service not identified above.

** Revised, effective October 1, 2005

Definitions and Acronyms

This section contains definitions, abbreviations, and acronyms used in this manual.

270/271 Transactions
The ASC X12N eligibility inquiry (270) and response (271) transactions.

276/277 Transactions
The ASC X12N claim status request (276) and response (277) transactions.

278 Transactions
The ASC X12N request for services review and response used for prior authorization.

835 Transactions
The ASC X12N payment and remittance advice (explanation of benefits) transaction.

837 Transactions
The ASC X12N professional, institutional, and dental claim transactions (each with its own separate Implementation Guide).

Accredited Standards Committee X12, Insurance Subcommittee (ASC X12N)
The ANSI-accredited standards development organization, and one of the six Designated Standards Maintenance Organizations (DSMO), that has created and is tasked to maintain the administrative and financial transactions standards adopted under HIPAA for all health plans, clearinghouses, and providers who use electronic transactions.

Administrative Rules of Montana (ARM)
The rules published by the executive departments and agencies of the state government.

Allowed Amount
The maximum amount reimbursed to a provider for a health care service as determined by Medicaid or another payer. Other cost factors, (such as cost sharing, TPL, or incurment) are often deducted from the allowed amount before final payment. Medicaid's allowed amount for each covered service is listed on the Department fee schedule.

Assignment of Benefits
A voluntary decision by the client to have insurance benefits paid directly to the provider rather than to the client. The act requires the signing of a form for the purpose. The provider is not obligated to accept an assignment of benefits. However, the provider may require assignment in order to protect the provider's revenue.

Authorization
An official approval for action taken for, or on behalf of, a Medicaid client. This approval is only valid if the client is eligible on the date of service.

Basic Medicaid
Patients with Basic Medicaid have limited Medicaid services. See the *General Information For Providers* manual, *Appendix A: Medicaid Covered Services*.

Centers for Medicare and Medicaid Services (CMS)
Administers the Medicare program and oversees the state Medicaid programs. Formerly the Health Care Financing Administration (HCFA).

Children's Health Insurance Plan (CHIP)
This plan covers some children whose family incomes make them ineligible for Medicaid. DPHHS sponsors the program, which is administered by BlueCross BlueShield of Montana.

Clean Claim
A claim that can be processed without additional information from or action by the provider of the service.

Client
An individual enrolled in a Department medical assistance program.

Code of Federal Regulations (CFR)
Rules published by executive departments and agencies of the federal government.

Coinsurance
The client's financial responsibility for a medical bill as assigned by Medicaid or Medicare (usually a percentage). Medicare coinsurance is usually 20% of the Medicare allowed amount.

Conversion Factor
A state specific dollar amount that converts relative values into an actual fee. This calculation allows each payer to adopt the RBRVS to its own economy.

Copayment
The client's financial responsibility for a medical bill as assigned by Medicaid (usually a flat fee).

Cosmetic
Serving to modify or improve the appearance of a physical feature, defect, or irregularity.

Cost Sharing
The client's financial responsibility for a medical bill, usually in the form of a copayment (flat fee) or coinsurance (percentage of charges).

Crossovers
Claims for clients who have both Medicare and Medicaid. These claims may come electronically from Medicare or directly from the provider.

DPHHS, State Agency
The Montana Department of Public Health and Human Services (DPHHS or Department) is the designated State Agency that administers the Medicaid program. The Department's legal authority is contained in Title 53, Chapter 6 MCA. At the Federal level, the legal basis for the program is contained in Title XIX of the Social Security Act and Title 42 of the Code of Federal Regulations (CFR). The program is administered in accordance with the Administrative Rules of Montana (ARM), Title 37, Chapter 86.

Dual Eligibles
Clients who are covered by Medicare and Medicaid are often referred to as "dual eligibles."

Early and Periodic Screening, Diagnosis and Treatment (EPSDT)
This program provides Medicaid-covered children with comprehensive health screenings, diagnostic services, and treatment of health problems.

Emergency Services
Those services which are required to evaluate and stabilize a medical condition manifesting itself by acute symptoms of sufficient severity (including pain) such that a prudent layperson, who possesses an average knowledge of health and medicine, could reasonably expect the absence of immediate medical attention to

result in placing the health of the individual (or unborn child) in serious jeopardy, serious impairment to bodily function or serious dysfunction of any bodily organ or part.

Experimental
A non-covered item or service that researchers are studying to investigate how it affects health.

Fiscal Agent
ACS State Healthcare LLC is the fiscal agent for the State of Montana and processes claims at the Department's direction and in accordance with ARM 37.86 et seq.

Full Medicaid
Patients with Full Medicaid have a full scope of Medicaid benefits. See the *General Information For Providers* manual, *Appendix A: Medicaid Covered Services*.

Gross Adjustment
A lump sum debit or credit that is not claim specific made to a provider.

Indian Health Service (IHS)
IHS provides health services to American Indians and Alaska Natives.

Individual Adjustment
A request for a correction to a specific paid claim.

Investigational
A non-covered item or service that researchers are studying to investigate how it affects health.

Kiosk
A "room" or area in the Montana Virtual Human Services Pavilion (VHSP) web site that contains information on the topic specified.

Mass Adjustment
Request for a correction to a group of claims meeting specific defined criteria.

Medicaid
A program that provides health care coverage to specific populations, especially low-income families with children, pregnant women, disabled people and the elderly. Medicaid is administered by state governments under broad federal guidelines.

Medicaid Eligibility and Payment System (MEPS)
A computer system by which providers may access a client's eligibility, demographic, and claim status history information via the internet.

Medically Necessary
A term describing a requested service which is reasonably calculated to prevent, diagnose, correct, cure, alleviate or prevent worsening of conditions in the client. These conditions must be classified as one of the following: endanger life, cause suffering or pain, result in an illness or infirmity, threaten to cause or aggravate a handicap, or cause physical deformity or malfunction. There must be no other equally effective, more conservative or substantially less costly course of treatment available or suitable for the client requesting the service. For the purpose of this definition, "course of treatment" may include mere observation or, when appropriate, no treatment at all.

Medicare
The federal health insurance program for certain aged or disabled clients.

Mental Health Services Plan (MHSP)
This plan is for individuals who have a serious emotional disturbance (SED) or a severe and disabling mental illness (SDMI), are ineligible for Medicaid, and have a family income that does not exceed an amount established by the Department.

Mentally Incompetent
According to CFR 441.251, a mentally incompetent individual means an individual who has been declared mentally incompetent by a federal, state, or local court of competent jurisdiction for any purpose, unless the individual has been declared competent for purposes which include the ability to consent to sterilization.

Mutually Exclusive Code Pairs
These codes represent services or procedures that, based on either the CPT-4 definition or standard medical practice, would not or could not reasonably be performed at the same session by the same provider on the same patient. Codes representing these services or procedures cannot be billed together.

PASSPORT To Health
A Medicaid managed care program where the client selects a primary care provider who manages the client's health care needs.

Prior Authorization (PA)
The approval process required before certain services or supplies are paid by Medicaid. Prior authorization must be obtained before providing the service or supply.

Private-pay
When a client chooses to pay for medical services out of his or her own pocket.

Provider or Provider of Service
An institution, agency, or person:

- Having a signed agreement with the Department to furnish medical care and goods and/or services to clients; and
- Eligible to receive payment from the Department.

Qualified Medicare Beneficiary (QMB)
QMB clients are clients for whom Medicaid pays their Medicare premiums and some or all of their Medicare coinsurance and deductibles.

Relative Value Scale (RVS)
A numerical scale designed to permit comparisons of appropriate prices for various services. The RVS is made up of the relative value units (RVUs) for all the objects in the class for which it is developed.

Relative Value Unit
The numerical value given to each service in a relative value scale.

Remittance Advice (RA)
The results of claims processing (including paid, denied, and pending claims) are listed on the RA.

Resource-Based Relative Value Scale (RBRVS)
A method of determining physicians' fees based on the time, training, skill, and other factors required to deliver various services.

Retroactive Eligibility
When a client is determined to be eligible for Medicaid effective prior to the current date.

Sanction
The penalty for noncompliance with laws, rules, and policies regarding Medicaid. A sanction may include withholding payment from a provider or terminating Medicaid enrollment.

Special Health Services (SHS)
SHS assists children with special health care needs who are not eligible for Medicaid by paying medical costs, finding resources, and conducting clinics.

Specified Low-Income Medicare Beneficiaries (SLMB)
For these clients, Medicaid pays the Medicare premium only. They are not eligible for other Medicaid benefits, and must pay their own Medicare coinsurance and deductibles.

Spending Down
Clients with high medical expenses relative to their income can become eligible for Medicaid by "spending down" their income to specified levels. The client is responsible to pay for services received before eligibility begins, and Medicaid pays for remaining covered services.

Team Care
A utilization control program designed to educate clients on how to effectively use the Medicaid system. Team Care clients are managed by a "team" consisting of a PASSPORT PCP, one pharmacy, the Nurse First Advice Line, and Montana Medicaid.

Third Party Liability (TPL)
Any entity that is, or may be, liable to pay all or part of the medical cost of care for a Medicaid, MHSP or CHIP client.

Timely Filing
Providers must submit clean claims (claims that can be processed without additional information or documentation from or action by the provider) to Medicaid within the latest of

- 12 months from whichever is later:
  - the date of service
  - the date retroactive eligibility or disability is determined
- 6 months from the date on the Medicare explanation of benefits approving the service
- 6 months from the date on an adjustment notice from a third party payor who has previously processed the claim for the same service, and the adjustment notice is dated after the periods described above.

Usual and Customary
The fee that the provider most frequently charges the general public for a service or item.

Virtual Human Services Pavilion (VHSP)
This internet site contains a wealth of information about Human Services, Justice, Commerce, Labor & Industry, Education, voter registration, the Governor's Office, and Montana. http://vhsp.dphhs.state.mt.us

WINASAP 2003
WINASAP 2003 is a Windows-based electronic claims entry application for Montana Medicaid. This software was developed as an alternative to submitting claims on paper. For more information contact the EDI Technical Help Desk (see *Key Contacts*).

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